

**HOW DO THERAPISTS WHO WORK WITH PEOPLE WITH
DIAGNOSES OF EATING DISORDERS TALK ABOUT THEIR
OWN BODIES?**

MARTHA KENYON

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Dedicated to Vera Azarova, joy embodied
(1985-2014)

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ABSTRACT

This thesis aims to explore how therapists construct their own bodies when working in the context of specialist eating dis/order¹ services, using Foucauldian Discourse Analysis (FDA). The first chapter is a critical review of the existing literature on the therapist's body within the specialist field of eating dis/orders, from perspectives of both research and practice.

The methodology consisted of nine semi-structured interviews, with seven clinical psychologists and two trainee clinical psychologists who work in specialist eating dis/order services, exploring how they construct their own bodies. The transcripts were then analysed using FDA. A critical realist social constructionist epistemological position was adopted, in order to highlight and explore the constructed nature of the body, the mechanisms of power at both local and institutional levels, and implications for subjectivity.

The analysis focuses around four dominant constructions of the therapist's body: (1) as both impacting on and impacted by the work, (2) as visible and watched, (3) as paradoxically both talked about and not talked about, and (4) within subject positions of perfect healthy professional and pathologised professional Other.

This thesis argues for the importance of embodied and elaborated constructions of the therapist's body, and openness to talk of the therapist's body, in therapy, supervision, and at a service level. This may facilitate reflection, therapist wellbeing, and provide richer more authentic ways of being embodied within the eating dis/orders service. It is hoped that this thesis contributes to the alternative embodied discourses available for both service users and providers.

¹ See section 1.1. Language

Figure 1: Blue Nudes, Henri Matisse, 1952. Gouache-painted paper cut-outs stuck to paper mounted on canvas. Reproduced with permission.



Around the time of starting this research I saw the Blue Nudes at The Tate Modern's Matisse Cut Outs exhibition. They struck me as a metaphor for my thesis: the blue nude's body is (literally) constructed in different ways and sustains a multiplicity of meanings and subjectivities.

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CHAPTER 1 - INTRODUCTION

'The body says what words cannot.'

Martha Graham, modern dancer and choreographer (Graham, 1985)

This thesis addresses the problem of the therapist's body in an eating dis/orders context. Adopting a Discourse Analytic approach the purpose was to explore how therapists who work in NHS eating dis/order services construct their own bodies in a context where bodies are central. I intended to elucidate how 'the therapist's body' is constituted in interview interaction between myself, a trainee clinical psychologist who previously worked in an eating dis/order service, and the participants.

Following Arribas-Ayllon and Walkerdine (2008) I am interested in the embodied differences, silences and paradoxes within participants' accounts. I argue that multiple discourses converge upon the therapist's body to produce it as uniquely professionally, personally and ethically problematic within the field of eating dis/orders. Therapists are constructed as under surveillance by colleagues, clients and themselves, which produces professional bodies as disciplined and docile. These discourses and technologies of power and self create a difficult environment for experts by both training and personal experience. I propose that constructions of the therapist's body in these interviews are strikingly similar to those converging, complex and sometimes contradictory discourses argued to produce eating dis/orders in the first place.

A Foucauldian discourse analytic framework can be used to disrupt discourses and power relations. I suggest that those who work in eating dis/orders re-evaluate current constructions of bodies and embodiment. Exploring alternative discourses around bodies may open up alternative, embodied ways-of-seeing and ways-of-being for therapists, their clients, and those who bridge the two identities. This introduction considers existing

literature and research regarding the therapist's body, both generally and specifically within the field of eating dis/orders.

My interest in researching the therapist's body was initially sparked by a conversation about my own body in supervision when working in an eating dis/orders service, prior to clinical psychology training. I found the conversation difficult, both in terms of having the vocabulary to talk about my body in a professional setting and my emotional response of shame and wanting to defend myself and my body. It was clearly also a difficult conversation for my supervisor. I had been aware of how my clients' eyes would often flick to my stomach in therapy, and I was asked on a number of occasions what my body mass index (BMI) was, and whether I had had an eating dis/order. Having found the supervision conversation so difficult and been told that my body would impact significantly on my clients and the therapy, I sought out guidance for addressing my body in therapy and supervision. I was taken aback by the paucity of literature on the subject of the therapist's body, both generally and specifically in the field of eating dis/orders. On clinical psychology training, I found that in three years of lectures there were only a handful of passing references to the therapist's body. Thus, my own experience of the significance attributed to my own body by both clients and a supervisor in an eating dis/order context, combined with a lack of formal guidance on the subject, drove my initial motivation for undertaking this research.

1.1. Language

This thesis takes a critical realist social constructionist approach, further elaborated upon in the methodology. However, this introduction will review literature from a wide breadth of epistemologies and theoretical approaches. Wherever possible I will rephrase authors' conclusions to reflect their socially constructed nature.

I have written this thesis in the first person in recognition that it is a construction, rather than an objective account. Where relevant, I have also included myself within the bracket of eating dis/order practitioners to acknowledge that I am not a disinterested observer, but have worked in the field of eating dis/orders and am an active participant in constructing the accounts found in this thesis.

Throughout this thesis I use the term eating dis/order and diagnostic categories such as 'anorexia nervosa' and 'bulimia nervosa'. I use these terms with awareness that they are social constructions (Hepworth, 1999) best understood within their social, cultural and historical context. This is in contrast with the dominant biomedical constructions of eating dis/orders as individual psychopathologies originating from within the (mostly) women diagnosed, who are separate and deviant from the norm (Malson & Burns, 2009). However, as I am interested in specialist services organised around the construction of eating dis/orders, I will use this term for ease of understanding. Following Malson and Burns (2009) I have separated the prefix 'dis' of the word 'disorder' to call into question the dominant construction of the supposedly pathological disordered bodies as separate from healthy ones. Additionally, I use the term eating dis/order because the repetition of 'people given a diagnosis of an eating dis/order' could be distracting to the reader. For readability I have refrained from repeatedly using quotation marks around terms highlighted as problematic such as 'mental illness', 'patient', 'treatment', 'professional' and 'anorexia nervosa'.

1.2. Foucauldian Discourse Analysis

Arribas-Ayllon and Walkerdine (2008) argue for three broad dimensions to a discourse analysis inspired by Foucault: firstly, an historical enquiry which he also called 'genealogy'; secondly, analysis and description of the mechanisms of power; and thirdly, analysis of subjectification. For the purposes of this

thesis I wish to add a fourth dimension, that of the body, which is central to much of Foucault's work. Quoted in O'Farrell (2005), Foucault states:

"I would like my books to be a kind of tool box which others can rummage through to find a tool which they can use however they wish in their own area." Foucault (1994, pp. 523-524)

I have drawn a number of concepts from Foucault's earlier works as a 'tool box' for application to the question of how the therapist's body is constructed within eating dis/order services, particularly Foucault's theorisation of governmentality and the regulation of the body (Foucault, 1977, 1979). He argues that technologies of power and the self are often material and take effect at the level of the body (McHoul & Grace, 1993). Therefore, the four broad concepts of historical enquiry, power, subjectification and the body are the foundations for this thesis.

1.3. Literature search

To review the literature for this study I searched EBSCO, an international online database resource (all databases selected and all years available). I repeated the search in November 2013, March 2015 and April 2017.

Combinations of the following search terms were used:

- (psychology*) or (therapist*) or (clinician*) or (professional*) or (psychotherapist*) or (counsel*) or (treatment provider*) AND
- (body) or (bodies) or (embodiment) or (appearance) or (physical) or (self) AND
- (eating disorder) or (anorexia) or (bulimia) AND
- (therapist body) or (therapist appearance) or (therapist experiences) or (personal history) or (therapist attitudes) or (therapist characteristics)

Later searches included combinations of the above with the following terms:

- (discourse) or (discursive) or (analysis) AND
- (accounts) or (talk) or (construction)

Abstracts were reviewed and full texts of articles, books or chapters that seemed relevant were obtained. I conducted a further hand search from the references of relevant papers and authors I knew had conducted research into this area. Regular Google Scholar searches and citation alerts were useful to highlight new literature.

In order to understand how the therapist's body came to be a problem in the field of eating dis/orders, the introduction of this thesis will briefly consider different approaches to the therapist's body in psychology and psychotherapy.

1.4. Brief History of The Body in Psychology

A short historical analysis will elucidate how the body has been constituted by psychology across the 20th and early 21st centuries. Euro-American psychology and psychotherapy are founded upon mind-body dualism. The construction of the rational subject arose during the Enlightenment and has dominated European and North-American discourse since that time.

Descartes (1596-1650) asserted that the mind and body are two different substances independent of one another. The conscious self and mind, the "I" or thinking substance, is distinct from the corporeal body. Cartesian dualism allows for the privileging of the rational mind and concomitant denigration of the body, which is constructed as merely a vehicle for the mind (McNay, 1992). This has meant that in contrast with cognition, bodies have been largely disregarded within psychological therapy, research and practice. The

absence of the body from therapy is definitional: psychotherapy is 'the talking cure' (Shapiro, 1996).

1.5. The therapist's body in approaches to therapy

Freud theorised that the ego was firstly a body ego (Freud, 1923) and develops from bodily experiences. Winnicott emphasised bodily experiences within the maternal caretaking environment as the basis of the development of the self, with the psyche as an 'imaginative elaboration of somatic parts, feelings and functions, that is, of physical aliveness' (Winnicott, 1949, p.244). Thus, experiences of the body are constructed as fundamental to development of the self.

Transference is a core psychodynamic principle (Freud, 1912). Initially, literature on therapist embodiment centred around accounts of psychotherapists experiencing unexpected physical sensations in response to clients, such as hunger or drowsiness (Dean, 1957). These bodily experiences were often explained in terms of transference and countertransference. Though it has been argued that traditional psychoanalytic practice has historically been almost entirely removed from bodily experience (Shapiro, 1996), more recently it has been claimed that the therapist's most valuable instrument is the therapist's own self (Yalom, 2011).

In the early 20th Century behaviourism adopted a model of the body as machine reduced to stimulus, response and reflex, and subjectivity was governed through detailed psychophysical measurement (Stam, 1998). The rise of cognitive psychology in the latter half of the 20th century was heavily influenced by mind-body dualism, and as such the body almost completely disappeared into a supporting role to perception and cognition. As a combination of cognitivism and behaviourism, the therapist's body is framed as largely irrelevant within cognitive behavioural therapy (CBT). One exception is the concept of 'modelling', where client learning occurs through

the observation and imitation of the therapist, for example in CBT for eating dis/orders the therapist might eat with the client in session (Waller et al., 2007). Beyond this, the therapist's body is absent from the cognitive-behavioural literature.

Early systemic literature attended to embodied or 'analogic' communication, such as how clients sit and use their bodies in therapy sessions (e.g. Minuchin & Minuchin, 1974; Watzlawick Beavin & Jackson, 1967). However, for decades interest in the body waned while meaning constructed through language was foregrounded in social constructionist approaches (e.g. Checchin, 1992). More recently there has been a resurgence of interest in the embodiment within systemic therapy. This includes Griffith and Elliott Griffith (1994) challenging the mind-body dichotomy by mapping the somatic consequences of psychological distress, Andersen (1996, 1998, 2012) bringing attention to embodied liveliness and change in therapy, Hardham (1996) writing on the therapist's use of embodiment in therapy, and most recently Bownas and Fredman (2017) exploring therapist embodiment in the supervisory process. The therapist's embodiment is increasingly acknowledged as an important factor in the therapeutic process reflecting the shift in dominance from first-order to second-order cybernetics, where the therapist becomes part of the family system in therapy and a participant in co-constructing reality (e.g. Hoffmann 1985, 1990).

There is a dearth of literature specifically addressing the therapist's body in eating dis/orders from a systemic perspective. This is despite the extensive evidence for, and services offering, systemic approaches to eating dis/orders, following the NICE guidelines (National Institute for Clinical Excellence, 2004). A full review of the extensive systemic literature on eating dis/orders is beyond the scope of this thesis (e.g. see Eisler, Simic, Russell & Dare, 2007; Lock & Le Grange, 2013).

However, despite systemic therapy's extensive literature on eating dis/orders and parallel emerging emphasis on the therapist's body, no literature has combined the two to address the particular challenges of embodiment facing

systemic therapists in the context of eating dis/orders. Thus, systemic research is not included further in this introduction's review of the literature.

We can see that recently attention to the body has been building. The importance of the client's body experience is now well established in research, theory and practice, particularly in the field of trauma (Ogden, Minton, & Pain, 2006; Rothschild, 2000; Van der Kolk, 1994, 2015). However, increasingly the therapist's body is being constructed as an object of interest, research and clinical relevance across therapeutic approaches and specialities. I will now turn my attention to the therapist's body in the particular field of eating dis/orders.

1.6. The body in eating dis/orders

Biomedical discourse is the foundation of eating dis/order services. However, the biomedical constitution of eating dis/orders as natural disease categories has been argued to be deeply problematic. While biomedical discourses recognise the physicality of the body, they construct the (mostly) female bodies as pathological. Women's distress around food, eating, embodiment and identity are presented as the symptoms of hypothesised illness, with risk factors such as genetic, neurological, emotional or cognitive dysfunction. Ussher (1992b) urges suspicion of reasoning implicitly founded on the female body as sick. Indeed, there is a lack of empirical evidence for individual risk factors despite extensive research (Botha, 2015). Attributing eating dis/orders to such internal causal mechanisms has been criticised for reifying eating dis/orders as individual pathology. However, these biomedical discourses persist as they support an ideological agenda: locating eating dis/orders within the individual obscures the complex sociocultural factors known to produce eating and body distress (Botha, 2015; Malson, 1998).

The centrality of the body and body practices in eating dis/orders is clearly demonstrated in the current ICD-10 diagnostic criteria for Anorexia Nervosa

(World Health Organization, 1992) such as: a Body Mass Index (BMI) of 17.5 or less; self-induced weight loss by avoidance of 'fattening foods'; and 'body-image distortion in the form of a specific psychopathology of dread of fatness' (p.117). Within these biomedical discourses the body becomes indicator of female pathology.

1.7. The therapist's body in eating dis/orders

Embodiment and the body are central to the experience of eating dis/orders, and the presence of the therapist's body is inescapable in therapy (Daly, 2016). Despite this, the therapist's body remains largely overlooked within published research on eating dis/orders (Lowell & Meader, 2005). When looking for guidance on addressing the therapist's body, the silence on the subject is striking. To date, no published research has explored the therapist's body from the therapist's perspective within eating dis/orders in the UK.

The majority of clinicians working in eating dis/order services are women, and subject to the same conflicting, restrictive cultural pressures about autonomy, femininity, goodness and the body as their clients (Matz & Frankel, 2005). Daly argues that even the most critically minded therapists feel the sociocultural pressures of appearance and attaining self-control over the body (Daly, 2016). However, this inclusive vision still contains subtle processes of individualisation and pathologisation, as Burka (1996, p.258) declares "some people are more susceptible to the socially constructed notions of beauty than others."

Therapy for eating dis/orders purports to challenge socio-cultural values such as overvaluation of thinness. However, feminist academics have argued that the discourses of eating dis/order contexts reproduce and consolidate the very conditions argued to give rise to eating and body distress in the first place (Malson et al., 2011). If unhelpful discourses are challenged whilst simultaneously reproduced, therapists who spend much of their time in eating

dis/order contexts may find their bodies constructed in powerfully complex and contradictory ways.

Most literature on the therapist's body in eating dis/orders consists of psychoanalytic therapists' reflective accounts of their own practice (Farrell, 2006; Lowell & Meader, 2005; Matz & Frankel, 2005; Petrucelli, 2007; Rabinor, 1995).

1.7.1. Psychoanalytic perspectives

Contemporary psychoanalytic perspectives are increasingly arguing for the importance of attending to the therapist's body. Looker (1998) proposes that rather than rushing to verbalisation, the therapist's task is to remain consciously embodied. Orbach (2003), a seminal feminist psychoanalyst, advocates addressing the body *qua body*: on its own terms rather than just symbolically. She ventures that the therapist's body presence, from their clothes, to the way they talk and the degree of bodily comfort they convey, may disturb, please or overwhelm the 'patient', and that this impacts upon the therapeutic relationship and 'treatment'. Through multiple examples she claims that, while therapists may be unaware of their body and feel like a 'mere brain' in therapy, her body is highly significant for her 'patients' (Orbach, 2004). She argues that acknowledging the intersubjective therapist's body can 'help transform the very anguished bodies that are our patients' experience of their corporeality' (Orbach, 2004, p. 149).

Burka (1996) provides a postmodern psychoanalytic perspective from a self-identified overweight therapist. She analyses maternal, competitive, and dismissive transference and countertransference responses to her 'large, culturally devalued' body. She reports that clients with eating dis/orders speak of feeling afraid while in her presence, as her body represents what could happen if they are not vigilant. She eloquently claims that her willingness to talk about her own body benefits the therapy:

“If my body is present and significant for me and my patients, but remains outside of the discourse of therapy, what kind of taboo have my patients and I created? What deadness is insured and what vitality is precluded? (...) are we agreeing that they must not attack a visible vulnerability of mine because that would be too dangerous? (I might be too fragile, or I might retaliate or withdraw from them.) Are they submitting to my power to set the limits for our discourse, silently signifying that certain topics are unspeakable? These collusions deaden the therapy and prevent an important object, the therapist’s body, from becoming a verbalised issue that can be elaborated and understood.” (Burka, 1996, p. 274)

Burka highlights issues of power in terms of what can and cannot be said in therapy. The client’s body is the main focus of the work in eating dis/orders and can be talked about in minute detail by the therapist. By making the therapist’s body unspeakable, creating a taboo, the therapist is exercising power. If the therapist is comfortable bringing their body into therapeutic talk, this may address the power differential and bring ‘vitality’ to the therapy.

1.7.2. The therapist’s body as a professional and ethical issue

In the past decade theoretical papers, mostly originating in North America, have constructed the therapist’s body as an important issue in terms of the treatment, supervision and professional ethics of working in eating dis/orders (Jacobs et al., 2010; Warren, Schafer, Crowley, & Olivardia, 2013b; Williams & Haverkamp, 2010).

In Williams and Haverkamp (2010), a panel of North American mental health professionals agreed critical competencies relating to the therapist’s body in order to practice ethically within the field. These included: self-awareness of the therapist’s own weight, shape, and size assumptions; to be able to ‘frankly’ discuss client concerns about their therapist’s weight and shape; ‘not to be personally experiencing active eating disorder symptoms’; and to have addressed their own food and body issues ‘to a high level of resolution’. Thus,

the therapist's body, their relationship to their body and ability to talk about their body are constructed as critical to professional competence.

A heated debate between professionals on the American Eating Disorders listserve website prompted a collection of essays on the therapist's body (Jacobs et al., 2010). The thread was sparked by a request for guidance on 'confronting a co-worker who was perceived to be "dangerously thin"'. Contributors recounted stories of being told by their colleagues that they were 'too thin' and 'triggered the patients', and it was implied overweight therapists 'lacked credibility' (Jacobs et al., 2010, p. 171).

Murray (in Jacobs et al., 2010), a self-identified person of colour and size with a history of an eating dis/order, described her credibility being questioned based on her physicality and how her position as a junior clinician prevented her speaking out about size bias. She suggests that the homogeneity of physical appearance in staff is unreflective of the diversity of clients and society at large. McGilley asks "How much does the focus of our field of treatment narrow our field of vision?" (Jacobs et al., 2010, p. 173).

Psychologists are ethically required to intervene if we suspect a colleague's professional competence is seriously impaired (HPC, 2016). While it is not illegal to discriminate on the basis of appearance or size, eating dis/orders are classed as a disability and thus a Protected Characteristic against discrimination under the Equality Act (2010) Thus, professional imperatives collide with ethical and legal constraints to render the therapist's body a problem in eating dis/order services.

Using scenarios to consider ethical issues particular to eating dis/orders, Warren and McGee (2013) emphasised self-awareness and holistic self-care of the body as essential to maintain wellness and ethical practice. They argue that the therapist's own issues regarding food and the body need to be recognised and addressed. Therapists are exhorted to be alert to signs of physical, mental or emotional impairment likely to impact on their clients. This should be within a broader framework of responsibility from supervisors,

employers, educators, and professional organisations (Warren & McGee, 2013).

1.7.3. Therapists with personal experience of living with an eating dis/order

Lowell and Meader (2005) suggest therapists who are thin will be assumed to have experienced a current or past eating dis/order by both clients and colleagues. Estimates of a history of an eating dis/order among professionals vary: 24% (Bloomgarden, Gerstein, & Moss, 2003), 27.3% (Barbarich, 2002), 30% (Warren, Crowley, Olivardia, & Schoen, 2009). But these are likely to be an underestimation due to stigma (Bowlby, Anderson, Hall, & Willingham, 2015). A service that actively welcome personal experience have reported as many as 85% of their therapists identified as having recovered from an eating dis/order (Costin & Johnson, 2002). It is unknown how generalisable these findings are to the UK as all studies so far have taken place in North America.

There is debate around whether therapists with personal experience of an eating dis/order should work in the field (Johnston, Smethurst, & Gowers, 2005). Therapists with personal experience have been considered to 'lack objectivity' and be 'vulnerable' to the work exacerbating body and eating difficulties (Johnston et al., 2005). Other concerns include inappropriate self-disclosure, relapse and secrecy (Costin & Johnson, 2002).

Some distinguish between those therapists who identify as 'recovered' versus 'in recovery' (Costin & Johnson, 2002) in terms of suitability. Several authors have suggested that the biomedical model has implications for belief in recovery. Presenting experiences of distress as stable internal dysfunction, whether that be as part of genetics, neurochemistry, or 'cognitive biases', makes recovery 'unimaginable' as the 'risk' remains within the individual (Malson et al., 2011). Thus, those positioned as 'psychiatric patients' are viewed as unable to recover (Adame & Knudson, 2007, 2008; Frese & Davis, 1997; Slade, 2009). The dominant biomedical model undermines the position of recovered healthy professional.

One study suggested that professionals who self-identified as having a history of an eating dis/order had lower levels of burnout, less cynicism and greater personal accomplishment (Warren et al., 2013b). It has been argued to bring strengths to their work and the service as a whole. These include: enhanced therapeutic skills, understanding, empathy, and shame abatement (Bowlby, 2008; Costin & Johnson, 2002; Williams & Haverkamp, 2015). Much of the research has emphasised that recovered therapists can represent hope, optimism and serve as role models (Bowlby, 2008; Johnston et al., 2005).

Costin and Johnson (2002) both describe how they actively seek to recruit staff who have personal recovery:

“It is not recovery alone that I am drawn to (...) It is more of a “been there, done that, over it,” attitude that I am attracted to in potential staff... My experience with recovered staff is that they exude confidence in understanding and dealing directly with the patients’ eating disorder symptoms while offering hope and inspiration that becoming fully recovered is possible.’ (Costin & Johnson, 2002, p. 296)

However, the above position of actively seeking recovered professionals is uncommon in eating dis/order services, with most therapists keeping their personal experience secret due to stigma, in contrast to substance misuse services. I argue that the difference is the framing of eating dis/orders as chronic and intractable, valued and supposedly visible that makes the recovered professional uniquely problematic in this area.

Costin & Johnson (2002) suggest that if services adopt a ‘neutral’ policy on the employment of those with a personal history of eating dis/orders, this often goes hand in hand with a ‘don’t ask, don’t tell’ atmosphere. While this may appear to respect the privacy of staff, it may make it more difficult for staff to speak of their experiences. The authors suggest that the danger of this approach is that a struggling staff member may feel unable to ask for help.

The idea that personal experiences of distress might be a resource to draw upon for the therapist is not new. The wounded healer discourse originated in Greek mythology and shamanistic traditions (Kirmayer, 2003). Applied to psychotherapy by Jung, the archetypal wounded healer has experienced personal suffering and through this becomes able to understand and help others (Jung, 1951).

1.7.4. Questions from clients: to disclose or not to disclose

Petrucelli (2007) reports that her most common question from clients is: “Do you or have you had an eating disorder?” There is much debate about the meaning of enquiries and how they should be answered. Rabinor (in Jacobs et al., 2010), rather than turning the question back on the client as therapists are traditionally trained, advocates for breaking the ‘taboo’ of self-disclosure as depathologising and validating.

Costin (in Jacobs et al., 2010), a self-identified recovered professional, described how when seeing her first client with anorexia, it did not occur to her not to disclose her own “insider” knowledge. She warns against assuming that what worked for the therapist will work for others. Her advice is to share what aided recovery, and to err on the side of non-disclosure.

1.7.5. Reflective accounts of the therapist’s personal experience

A number of practitioners have written reflective accounts arguing for the importance of attending to and addressing the therapist’s body in eating dis/orders therapy. These mostly come from North American writers from a psychoanalytic tradition.

Matz and Frankel (2005) assert that eating dis/order clinicians internalise the ‘dysfunctional eating’ and ‘fat-phobic’ norms of our culture, with implications for our work. Warning against the assumption that it is better and healthier to be thin than fat, they urge therapists to model a ‘normal’ relationship with their body. However, there is no critical awareness of concepts such as ‘normality’

and such cultural-media accounts have been criticised as overly simplistic, not attending to wider power dynamics (Eckermann, 2009).

Lowell and Meader (2005) explore the meaning and impact of the thin therapist's body in eating dis/order work. They give an account of a client who in fantasy idealises her thin therapist as successful, desirable, happy, and married, and how the client believes the therapist cannot understand her struggle.

Petrucelli (2007) constructed clients' reactions to her appearance in terms of transference. She contended that paying attention to body-to-body interaction is particularly pertinent in eating dis/order work, where issues of body comparison, idealisation, denigration or envy may help or hinder change. She concludes that if therapists are able to tolerate their body being used tranferentially to articulate unspoken feelings, it can make the therapeutic relationship stronger and 'for someone with an eating disorder or disordered eating, may be the greatest gift we can give them' (p.253).

Rabinor and Derenne (2006) provided a reflective account of an American psychiatrist working with children given a diagnosis of an eating dis/order in an inpatient unit, and how this had impacted her body, both in terms of behavioural changes in eating and embodied experiences of being self-conscious and insecure.

1.7.6. The therapist's body in supervision of eating dis/orders work

Supervision and consultation with colleagues has been emphasised as one of the most helpful ways of managing difficult personal feelings arising from working with eating dis/orders (Franko & Rolfe, 1996). A number of supervision models adapted for work with eating dis/orders have drawn particular attention to the therapist's body.

Hamburg and Herzog (1990) highlight countertransference issues and the risk of parallel processes in supervision that mirror those of therapy. In a

supervision model for therapists leading outpatient eating dis/order groups, DeLucia-Waack (1999) argued for the importance of bringing discussions of the body into supervision. She contends that eating dis/order work needs exceptional self-awareness, and describes a parallel process by which difficulties of group members can inadvertently be mirrored and reinforced by facilitators, such as secrecy, body image, and attitudes to food and weight.

Thus, models of supervision for eating dis/order therapists encourage reflection on the therapist's body and eating. However it is unclear as to whether this occurs in practice, and what these conversations might look like.

1.8. Research into the therapist's body in eating dis/orders

In this section I contextualise the present study in relation to previous findings by critically reviewing studies that have explored the therapist's body within eating dis/orders. A realist medical model largely influences current research relating to eating dis/orders. As there is very limited social constructionist research specifically on the therapist's body, I will consider empiricist research into the therapist's body from clients' perspectives, then from therapists' themselves. I will also briefly introduce feminist poststructuralist contributions to literature in eating dis/orders.

1.8.1. Therapist's body from the client's perspective

A number of studies have explored clients' perspective on their therapist's body in eating dis/orders. The quality of the therapeutic alliance has long been viewed as central to therapeutic process and the best predictor of therapeutic outcome (Horvath, 2005). There is considerable literature exploring the contribution of therapist characteristics to alliance and outcome, for example gender (Waller & Katzman, 1998). Client willingness to engage in the therapeutic process may be influenced by their expectations of, and preferences in, their therapist (Glass, Arnkoff & Shapiro, 2001).

Considering the high value placed on weight and shape and hyper-attentiveness to the body, clients with body distress may be acutely aware of their therapists' physical appearance. In the context of conversations about eating, weight and shape, it is unsurprising that the therapist's body would be observed and potentially come under scrutiny by the client. It has been suggested that the 'thin' therapist may be seen as a competitor by their clients and lack credibility when trying to encourage weight gain, enhance body acceptance and 'normalise' eating (Anderson & Corson, 2001; Frankenberg, 1984; Kaplan & Garfinkel, 1999). Similarly, it has been suggested the larger therapist might trigger further fear of gaining weight, due to therapists' modelling role (Zunino, Agoos, & Davis, 1991). Thus, the therapist's body may impact on engagement, therapeutic alliance, and therapeutic outcome.

Four studies to date have addressed clients' view of their therapist's body in the context of eating dis/orders, with two specifically looking at the therapist's body during pregnancy.

Vocks, Legenbauer, and Peters (2007) in Germany took a quantitative realist approach to preferences of women living with eating dis/orders in an ideal female therapists' body. 34 women given diagnoses of eating dis/orders were compared to 30 given anxiety diagnoses on questionnaire responses to the question "if you imagine the ideal female therapist, which figure would she have?" Both expressed preference for the 'average' figure, but the eating dis/order clients rated their therapist's figure as more 'important'. The authors suggest that the female therapist's figure might impact her perceived credibility. However, this study reduces complex body-to-body interactions to the appearance of hypothetical figures on a scale, and does not address client's lived experience of their therapist's embodiment.

Given issues around sexuality and fertility, two studies have looked specifically at client experiences of the pregnant therapist's body. In an unusual mixed-methods design in the United States, Katzman (1993) examined responses to her own pregnancy of 24 of her clients given a

diagnosis of bulimia nervosa. She used a client behaviour checklist before and after announcing the pregnancy, process notes, and a one-year follow up questionnaire completed by clients. Katzman concluded that her pregnancy uncovered unvoiced concerns about sexuality, competition, abandonment, anger, jealousy and fertility. However, issues of power, deception and consent are problematic in this study conducted by a dual-role therapist-researcher.

In a Belgian study by Vandereycken and DeKerf (2010), 69 women and adolescent girls given a diagnosis of an eating dis/order completed questionnaires about experience of another person's pregnancy, including their therapist. Reported results included negative influence on their own body perception, increased fear of fatness, and positive influence on views of pregnancy and womanhood. However, this retrospective study viewed client questionnaire responses as a direct window onto their experience. Such reductionist quantitative methods fail to capture the nuances and complexity of experiences of the therapist's body.

Addressing this limitation Rance, Clarke, and Moller (2014) in the UK conducted a thematic analysis of interviews with 12 recovering women given a diagnosis of an eating dis/order about their female counsellor's body. Themes suggested that women observed and made assumptions about their female therapists' bodies. The thin therapist was variously seen as aspirational, envied, endorsing undereating, and applying a 'double standard' whereby the therapist but not the client was 'allowed' to remain thin. Few women had worked with a 'fat' therapist, though such an embodied therapist was suggested to be undesirable. The authors suggest judgements of the therapist's body in turn impacted on their belief in the therapist's ability and their willingness to engage in therapy. The authors postulate that high dropout rates may be related to not addressing client preferences and expectations regarding their therapist's body. This is significant given poor engagement and outcomes in eating dis/orders. The limited sample size precludes generalisation, however this is one of the first published studies in the UK to address the therapist's body using critical realist epistemology and qualitative methods.

This limited research suggests that the therapist's body is significant to clients, both generally and specifically during pregnancy. If this is the case, it seems vital that therapists practice body reflexivity (Rance et al, 2014). Anecdotally, Rance, Moller, and Douglas (2010) recount a therapist working in eating dis/orders who reported that it had not occurred to her to consider that clients might look at her.

I will now consider research exploring the therapist's perspective on their own body within eating dis/order services.

1.8.2. The therapist's body from the therapist's perspective

1.8.2.1. Quantitative research

Risks of therapist burnout have been highlighted in eating dis/order work. People given diagnoses of eating dis/orders are widely characterised as 'undesirable' clients and 'one of the most frustrating and challenging psychopathologies to treat' (Burket & Schramm, 1995; Vitousek, Watson, & Wilson, 1998). A review of 20 empirical studies indicated that clinicians' reactions to clients given an eating dis/order diagnosis were more negative than for other populations, and negative reactions were associated with inexperience; feelings of frustration and incompetence; lack of improvement and high mortality rates (Thompson-Brenner, Satir, Franko, & Herzog, 2012).

One study found that features of the therapist's body was correlated with therapist burnout in eating dis/orders (Warren, Schafer, Crowley, & Olivardia, 2013a). Burnout was associated with being a woman, being younger, and having a higher BMI. Thus professionals' experiences of working in eating dis/orders seemed to be intimately linked to their body.

The limited research available constructs being immersed in an eating dis/orders service as altering professionals' experience of their own body. Two anonymous questionnaire surveys of North American eating dis/order

conference attendees looked at the impact of the work on professionals and their bodies. Professionals came from a wide range of backgrounds.

Shisslak, Gray, and Crago (1989) analysed questionnaire responses from 71 professionals. 28% reported having been 'moderately to greatly affected by their work with eating dis/order patients' including changes in eating, body image, embodied feelings, and heightened awareness of health and appearance. However, there is lack of methodological detail to verify quality and to current services.

Similarly, Warren et al. (2009) took a mixed-methods approach to 43 conference attendees' questionnaires. 83% of respondents reported they felt their appearance had been "monitored, examined or evaluated by [their] eating disorder patients, even when the patient did not verbalise that this was happening". On average 25% of their clients had commented on their appearance. 13% reported they had received criticism, for example being called "old" or "fat". The authors concluded that 'commentary on the physical appearance of treatment providers is normative'. Professionals reported changes in food and eating, and increased vigilance about their own and others' appearance. Effects of the work on the therapist's body were constructed as both detrimental and an inherent part of eating dis/orders work: "one of the hazards of working in the field" (Warren, et al., 2009, p. 38). The authors described personal effects of the work as 'taboo' and suggest these results may represent 'the tip of the iceberg'. They argued that it is crucial for professionals in eating dis/orders, especially trainees, to have a forum to openly process experiences such as the impact of the work.

One unpublished study has looked at the therapist's body in UK eating dis/order services (Russell & Mountford, 2014). On a mixed-methods questionnaire, 13/17 reported their gender impacted on their work and 12/17 reported their own body image impacted on body image work. However, themes of 'denial' constructed therapist body image as a 'no-go area' with colleagues (Russell & Mountford, 2014). Conclusions are necessarily tentative due to the small sample, unclear method and lack of peer review.

Thus, a limited number of quantitative realist questionnaire studies suggest that working with eating and body distress adversely affects professionals' body and relationship with their body.

1.8.2.2. Qualitative research

Williams and Haverkamp (2015) explored eating dis/order therapists' perceptions of the professional and ethical relevance of their own eating dis/order history. Interpretive description analysis was conducted on 11 interviews. The study is relevant in that many of the issues raised referenced the therapist's body. Even in relatively accepting contexts participants reported challenging experiences. Similarly to Warren et al (2009), participants reported feeling that their body, appearance and behaviour were 'watched' by colleagues. Some gave accounts of their degree of wellness being questioned. Negative staff attitudes and norms of non-disclosure were constructed as unhelpfully inhibiting discussions and development of self-awareness. Furthermore, such atmospheres impacted client care by perpetuating shame, secrecy and avoidance. The value in having safe trusted supervisors and/or mentors where therapists could talk openly was highlighted. This highlights issues of stigma in relation to the therapist's body.

Exploring the meaning of eating dis/order 'recovery' to recovered professionals, Bowlby et al. (2015) conducted phenomenological analysis of 13 interviews. Though the study was not about the therapist's body *per se*, the importance of the body can be seen, as put by this therapist-participant:

"With eating disorders (sic), so many live in their head. People are disembodied and talking about therapy. The problem is that they are not in their bodies... I think there is a way to model an embodied stance that has a lot to offer with eating disorders... The scariest thing for people I think is to be sexual, sensual, aggressive. Yet that is exactly what they want, in a way. I don't know at what point they become two-dimensional in their mind, but in the eating disorder they

are just a visual image to themselves. It is just tragic because they are living on the fringes of themselves... Recovery is an incarnation of the whole body and getting in touch with those drives.” (Bowlby et al., 2015, p. 6)

FDA seems a prescient lens to apply to the above extract. The participant troubles discourses of mind-body dualism in eating dis/order recovery: the person becomes ‘disembodied’, ‘two dimensional’, and ‘not in themselves’. Reflecting embodiment and feminist discourses, recovery is constructed as ‘an incarnation of the whole body’ and getting in touch with being ‘sexual, sensual, aggressive’. Thus, the therapist’s role in eating dis/orders can be to ‘model an embodied stance’.

The empiricist literature suggests that the therapist’s body is of particular significance when working with eating and body distress. The therapist’s body and ‘body image’ appear to both effect, and be effected by, the work. Similarly, the therapist’s body seems to be commented upon by clients and colleagues. A number of authors reference an atmosphere of not talking about the therapist’s body, despite open discussion with understanding others such as supervisors being highlighted as vital in managing these experiences, self-awareness and ethical practice. However, the majority of these studies are founded on the medical model and adopt a realist stance that focuses on appearance and behaviour, conceptualising the body in a reductionist manner (Ussher, 2008).

1.8.3. Post-structuralist feminist perspectives

Since Orbach (1978) proclaimed that *Fat is a Feminist Issue*, there have been many strong critical feminist voices within the literature on women’s eating and body distress. Though there is no singular feminist voice (Ussher, 1991), post-structuralist feminist perspectives radically question biomedical positivist assumptions, problematising the supposition that language is a transparent window through which to observe the world. Rather, biomedical discourses that claim to be ‘neutral’ and ‘objective’ have been shown to be constitutive of

reality: decontextualising, individualising and pathologising embodied distress (Malson & Burns, 2009). Thus, post-structuralist feminist approaches emphasise context, gender, embodiment, language and multiply-constituted subjectivity. Foucault's (1977, 1979) historical analyses of the body as a key site where power is enacted have been highly influential (Eckermann, 2009), widely applied to understandings of self-starvation (Bordo, 1990; L. Eckermann, 1997; Hepworth, 1999) and the social construction of eating dis/orders more generally (Katzman, 1998; Malson & Burns, 2009).

Foucault's professor Merleau-Ponty (2002) asserted the importance of embodiment by claiming that absolutely all experience depends upon living bodies for its nature, and very existence. Over the past 20 years there has been a turn towards the body in feminist, critical and poststructuralist approaches (Britzman, 2000; Burns, 2006; Coffey, 1999; Ellis & Bochner, 1996; Fine, 1994; Richardson, 1997). Over time, the term 'the body' has been replaced with 'embodiment'. This change corresponds to a shift from viewing the body as a nongendered, prediscursive natural phenomenon to a way of living or inhabiting the world.

There is considerable post-structuralist research into embodiment in those who have been given a diagnosis of an eating dis/order (e.g. Blood, 2004; Bordo, 1993b; Malson, 1998). However post-structural research focussing on the embodiment of the clinicians who work with them is limited.

The most relevant literature to this study to date is that of Surtees (2009), who provides an autoethnographic feminist Foucauldian discourse analysis of her experiences of embodied slimness in a New Zealand eating dis/orders unit.

Surtees discusses the importance of visibility of the body as a signifier within health and biomedical discourses that maintain the dualism of professional One versus pathologised Other. The presence of thin bodies in the psychiatric eating dis/order unit are constructed as troublesome, as disordered eating is not necessarily visible. Embodiment and talk about 'professionalised bodies' parallels that of 'pathologised bodies', reinforcing the micro-management of

bodily regulation within discourses of 'health'. She describes the paradox of 'living the slash' between the professionalised/pathologised body, where in her personal life societal discourses of health and fear of fatness constitute her body as 'slim', 'skinny' or 'healthy'. However, when she crosses the threshold into the professional/medical space of the eating dis/orders unit she becomes 'thin'. However, this is an account of a nurse in an inpatient unit and no published research to date has looked at therapists' accounts of their own bodies in UK eating dis/order services.

1.9. Rationale for the current study and relevance to clinical psychology

Below I will summarise why the therapist's body is important, the rationale for this research, and its relevance to clinical psychology.

An eating dis/order diagnosis is associated with severe health complications and some of the highest levels of mortality of mental health diagnoses (Katzman, 2005; Mehler, Crews & Weiner, 2004; Treasure, Claudino & Zucker, 2010). The field is plagued by poor treatment uptake, adherence and outcomes (Brown & Keel, 2012), high drop-out rates (DeJong, Broadbent & Schmidt, 2011), poor recovery rates and chronic relapse (Carter, Mercer-Lynn, Norwood, Bewell-Weiss, Crosby, Woodside & Olmsted, 2012). Psychological therapies have relatively low levels of impact for people diagnosed with anorexia nervosa in particular, and there is no clear difference in outcome between such treatments (Waller, 2009). Given these poor outcomes, it is crucial that we better understand how to improve the therapeutic alliance. Recent research has suggested that client assumptions based on their therapist's body can impact client engagement in therapy, especially if these assumptions are not talked about in therapy (Rance *et al.*, 2014). None of the existing therapeutic approaches for eating dis/orders attend to the therapist's body. Addressing the therapists' body may be significant for vital improvement in outcomes in eating dis/orders.

Working in the speciality of eating dis/orders has been characterised as having a particularly strong impact on clinicians' own sense of embodiment. It has been described as one of the 'most frustrating and challenging' fields (Vitousek *et al.*, 1998) and is associated with high levels of therapist burnout, particularly for therapists inhabiting younger, female, or higher BMI bodies, suggesting that negative impact of the work is intimately linked to therapist physicality (Warren *et al.* 2009, 2013a). Therapists have described the work as affecting their eating, exercise habits, relationship to their body, and vigilance about their own and others' appearance in ways that were detrimental (Shisslak, Gray & Crago, 1989; Warren *et al.* 2009). Maintaining holistic therapist wellness is critical to ethical practice. Supervision and consultation with colleagues have been recommended for managing difficult consequences of the work for the therapist's body and their relationship to their body (e.g. Franko & Rolfe, 1996; DeLucia-Waack, 1999; Warren & McGee, 2013). However, it is unclear whether and how supervisors and supervisees are able to talk and reflect upon embodiment in supervision.

The literature suggests the therapist's body is particularly meaningful and important to clients given a diagnosis of an eating dis/order (Vocks *et al.*, 2007). Therapists report feeling watched and there are numerous accounts of client questions and comments about their therapist's body (e.g. Warren *et al.* 2009). Clients report making assumptions about therapist credibility and eating dis/order history based on the therapist's body (e.g. Andersen & Corson, 2001; Katzman, 1993; Rance *et al.*, 2014). It has been argued that being able to address client concerns about the therapist's body is a critical competency for work in this area (Williams & Haverkamp, 2010). However there is no research into *how* therapists can talk about their bodies and so how they would be able to address this issue with their clients.

Though assumptions linking therapist competence and appearance were previously attributed to so-called 'cognitive biases' in eating dis/orders (Rance *et al.*, 2014), therapists make similar negative judgements about their colleagues' wellness (as 'dangerously thin') and competence (as 'lacking credibility') based on their body (Jacobs *et al.* 2010). This seems to be linked

to the idea that therapists who fall outside what is considered the 'normal range', such as thin therapists, are attracted to the field due to experiencing a current or past eating dis/order themselves (Lowell & Meader, 2005). There is much controversy as to whether therapists with past personal experience of an eating dis/order should work in the field (Costin & Johnson, 2002; Johnson *et al.* 2005; Warren *et al.* 2013), and to what extent therapists' bodies are legitimately the business of their colleagues (Johnson *et al.* 2010). Drawing links between a therapist's body and their competence throws up a minefield of personal, professional, ethical and legal issues from fitness to practice to discrimination. Given this complexity it is crucial to elucidate how sensitive conversations might be had that address and navigate these various issues, in order to inform broader clinical governance from supervisors, employers, training and professional organisations (Warren & McGee, 2013).

The literature is in agreement about the importance of addressing the therapist's embodiment and its meaning to clients in therapy and supervision, as well as promoting wellness and self-awareness of the body through reflective practice. However, the therapist's body is described as taboo in eating dis/orders contexts (Warren, 2009 *et al.* 2009; Jacobs *et al.* 2010). It is unclear to what extent services, supervisors and therapists make space for conversations addressing the therapist's body.

This thesis makes a novel contribution to the literature on the therapist's body in eating dis/orders in two major ways. Firstly, no previous published research has addressed the therapist's body from the therapist's perspective in the UK. Secondly, it is the first study to utilise FDA in addressing therapists' accounts of their own bodies. FDA allows attention to the complexities, silences and paradoxes of talk (Arribas-Ayllon & Walkerdine, 2008). Thus, the present research study has sought to illustrate *how* the therapist's body is made particularly problematic by the discourses of eating dis/orders services. Commitment to retaining complexity and detailing of the functions of power make this study a unique contribution to the literature on the therapist's body in eating dis/orders.

Despite its significance to clients, colleagues and therapists themselves, the therapist's body in eating dis/orders seems a neglected area for research and clinical practice in UK NHS contexts. No published research to date has looked at the therapist's body from therapists' own perspective in the UK. Furthermore, despite extensive post-structural and feminist research methods, particularly FDA, being applied with great effect to expand our understanding of eating dis/ordered subjectivities (e.g. Malson & Burns, 2009), such methods are yet to be applied to therapists' talk of their own bodies in UK eating dis/order services. There is a dearth of literature (i) examining *how* therapists who work in the field of eating dis/orders are able to talk about their own bodies; and (ii) analysing of the functioning of discourses and power in these constructions, questions which could be addressed using FDA. The findings of this study can inform clinical psychologists' practice regarding their body in therapy, supervision, reflexivity, self-care, and guidance from training, services and professional bodies.

1.10. Research Questions

This thesis explored constructions of the therapist's body in eating dis/order services. I hope to make a novel contribution to theory and practice by deploying a FDA methodology to address implications for power and subjectivity. Underpinning this thesis is a theoretical orientation towards feminism, subjectivity and power informed by the ideas of Foucault. The formulation of my research questions was partly guided by Surtees (2009), to date the only other FDA addressing the therapist's body within eating dis/orders.

The broad research question was as follows: 'how do therapists working within the specialism of eating dis/orders talk about their own bodies?' This aim was addressed via four sub-questions focussed around problematisation, technologies of power and self, subject positions and processes of subjectification adapted from Arribas-Ayllon and Walkerdine (2008):

- 1) How is the discursive object of the therapist's body constituted and made problematic? What discourses are available?
- 2) How is therapists' conduct governed at a distance (technologies of power) and by therapists themselves (technologies of self)?
- 3) What embodied subject positions and practices are made possible within these discourses?
- 4) How do clinicians take up, negotiate and contest these processes of subjectification?

The next chapter sets out the theoretical and methodological framework used to address these questions.

CHAPTER 2 - METHODOLOGY

This research aims to explore how therapists working in the field of eating dis/orders can talk about their bodies. This chapter provides a rationale for the methodology and method chosen, which includes using a critical realist social constructionist epistemological position and Foucauldian Discourse Analytic approach. The method is detailed including participants, data collection, transcription and analysis. I conclude with an account of my positioning. A critical review and further reflection are provided in the final chapter.

2.1. Methodological rationale

Qualitative methods are best suited to research aiming to develop rich descriptions and understandings of phenomena (Harper, 2012). They can explore participants' lived experience and self-defined meaning given to that experience (Willig 2013). As I am interested in the subtleties of therapists' talk about their bodies in eating dis/orders services qualitative methods seem most useful, especially as there is little current knowledge in this area.

2.2. Epistemological position

I am taking a position of critical realist social constructionist epistemology and critical realist ontology informed by Harper (2011). Epistemology is the theory of knowledge, what can be known and how: 'the study of the nature of knowledge and the methods of obtaining it' (Burr, 2003, p 202).

2.2.1. Critical realist social constructionism

I am interested in the constructed nature of 'reality' through language and social context, a social constructionist concern (Burr, 2003). This research aims to produce knowledge of *how* experience is constructed, rather than in making claims about 'reality'.

I subscribe to Gergen's (1985) four principles of social constructionism, paraphrasing Burr (2003):

- 1) A critical approach to taken-for-granted knowledge;
- 2) Knowledge is historically, socially and culturally located;
- 3) Social and cultural processes influence and sustain what is taken to be 'true';
- 4) Knowledge and social action are inseparable: the ways we talk, write and construct the world are not 'neutral' but rather maintain certain viewpoints to the exclusion of others.

Put simply, knowledge is constructed through language. The role of the social constructionist researcher has been likened to that of an architect looking at how an object is created, and from what materials (Willig, 2012). Adopting a social constructionist epistemology I am interested in tracing how knowledges of the body is constructed through talk; what historically, socially and culturally located discourses about bodies are available to my participants; the effects of being positioned within these discourses; and the implications for power and subjectivity.

I take a 'weak' social constructionist approach asserting the need to go beyond the text and ground discourses used within social, cultural, political and material contexts (Willig, 2012). This position has an affinity with that of critical realists. From this position I am concerned with the ways in which discourses available to participants constrain what can be said and done within the specialist eating dis/order services (Willig, 2012).

2.2.2. Critique of social constructionism

Social constructionism has been criticised for 'dis-embodiment' psychology in favour of language (Nightingale & Cromby, 1999; Ussher, 2008). I find this ethically problematic in eating dis/orders where the stakes of embodied distress are so high.

Ussher's critical-realist work on embodiment has strongly influenced my position (Ussher, 2011). I adopted a material-discursive approach which views 'real' corporeality as always mediated by culture, language, and subjectivity (Ussher, 2008). Ussher (2008) warns against the either/or approach of mind/body dualism, and advocates a more nuanced position to 're-embodiment psychology'. The body is not a passive inscribed surface, a construction that dismisses embodied distress and the physical effects of purging and starvation. Rather, the body is constitutive of discursive constructs and subjectivity, and actively sustains particular constructions over others. Holding the ambivalence of seemingly contradictory approaches strikes me as similar to the systemic position of both/and (Burnham, 1992). A material-discursive approach has been widely adopted, for example applied by Malson (1998) who demonstrates how the discursive and material practices of the thin/'anorexic' body can be seen as paradoxically self-productive of identity/subjectivity and self-destructive, in the most extreme case as death.

Adopting a critical realist social constructionist epistemology with critical realist ontology and using a material-discursive approach allows me to address embodiment.

2.2.1. Critical realist ontology

Taking a critical realist ontological position, I align myself with such thinkers as Parker (1992; 1998), who upholds that there are underlying structures in the world, our knowledge of which is mediated by language to produce different social constructions. I maintain that there is an underlying 'reality' on

which discursive constructions are grounded, but do not see the data as a transparent window.

Thus I am making ontological claims about the pre-existing materiality of the body that can influence discourse. This epistemologically relativist and ontologically critically realist position has traditionally been taken by researchers who use Foucauldian approaches to discourse analysis (Arribas-Ayllon & Walkerdine, 2008; Parker, 1992, 1998, 2005). It has been demonstrated to be useful in feminist, embodied approaches to research (see Ussher, 2008).

Epistemological debates can be seen to map onto ethical debates in psychology (Willig, 2012). Ontological relativism, where there is seen to be nothing extra-discursive, is problematic to me in terms of addressing power and taking up an political and ethical stance (Willig, 2008). Following Parker (2005) my epistemology and ontology are informed by my own commitments to feminism, critical psychology and embodiment.

2.3. Method: Foucauldian Discourse Analysis (FDA)

The most common method currently adopted by those looking to produce social constructionist knowledge is discourse analysis. Discourse analysis has various forms such as discursive psychology, FDA, and critical discourse analysis. I chose to use FDA as detailed by Arribas-Ayllon & Walkerdine (2008) for a number of reasons, detailed below.

FDA is well suited to answering research questions underpinned by theoretical preoccupations of feminism, subjectivity, power and the body. It lends itself to capturing ambiguity, ambivalence, contradiction and complexity. Such a method allows for focus on how the social world of the eating dis/orders unit is constructed through language and shaped by processes of power (Willig, 2008).

Foucault emphasises the link between power and knowledge and how particular ways of viewing the world are embodied in certain institutions (Foucault, 1977, 1979). FDA methodology provides a framework for the exploration of language and power in the eating dis/order unit: what can and cannot be said about professionals' bodies, by whom, where and when, and the implications for experience and conduct (Willig, 2013). FDA takes the power/knowledge relations of psychological theories and practices into account (Arribas-Ayllon & Walkerdine, 2008). Discourse is understood as constituting reality (Burman & Parker, 1993; Potter & Wetherell, 1987), and FDA can offer an exercise in the 'gathering of clues' (Rose, 1979) to understand how eating dis/order services are engaged in the constitution of the therapists' body. Unlike discursive psychology, FDA allows interpretation beyond the text (Arribas-Ayllon & Walkerdine, 2008). This is pertinent within eating dis/order contexts as historical socio-cultural discourses have been argued to be particularly relevant in this field (Malson & Burns, 2009).

Finally, there is a strong tradition of applying FDA within feminist approaches that have contributed significantly to understandings of eating dis/orders (e.g. Bordo, 1991; Malson, 1998; Malson et al., 2011). However, FDA is yet to be applied to how the therapist's body is constructed in eating dis/orders. The present study will build on existing feminist FDA knowledges and address the gap in the literature.

2.4. Ethics

Ethical approval was sought and granted from the University of East London Research Ethics Committee (Appendix 1). NHS ethical approval was not necessary to interview NHS staff as they are not considered vulnerable by current ethical policies.

2.5. Procedure

It is important to collect data that maps onto the research questions; that sufficiently warrants the kind of claims this thesis wishes to make; and that match the epistemological assumptions of the method of analysis (Harper, 2011). Following previous FDA methodologies (e.g. Malson et al., 2011) this thesis used interview data for the reasons detailed below.

2.2.1. Data collection

FDA can be utilised 'wherever there is meaning' (Parker, 1999, p. 1). Willig (2013) suggests that to find out how people construct meaning in relation to a topic, such as their own bodies, one can work with semi-structured interview transcripts or focus group discussions. Data was collected using semi-structured interviews with therapists working in eating dis/order services.

I am aware of the critiques of using interviews for discourse analysis as an 'unnatural' interaction (Potter & Hepburn, 2005). In an ideal world, discourse analysis should be applied to naturally occurring text or talk (Hepburn & Wiggins, 2005). However, there are both ethical and practical challenges for collecting naturally occurring data on how therapists construct their own bodies, based on the existing literature. Firstly, this is a phenomena that has been highlighted more by its *absence* from talk than by its presence, in that is seen to be a taboo subject. Secondly, when therapists' bodies are talked about, it is often in spaces that would be difficult to access, such as over lunch or with fellow clinician friends outside of work. Ethical considerations include the challenges of confidentiality when recording supervision or therapy sessions. Finally, the construction of therapists' bodies involves the extra-discursive, for example the physical practices that render the body problematic within the eating dis/order unit (Surtees, 2009), and thus would not necessarily be constructed through text or naturally occurring talk. The possibility of collecting sufficient 'naturally occurring' talk within the time

constraints of this thesis was limited. Thus, it is necessary to take an 'interventionist approach' in collecting data (Potter & Wetherell, 1987).

To inform my choice of data collection procedure I informally consulted with eating dis/order clinicians. Regarding focus groups they suggested they would not volunteer to talk about their experiences of their body within a group of other eating dis/order professionals. The reasons they gave were that it felt very personal and they feared judgement. Similarly, when consulted about diaries they reported they would not wish to keep a diary, as this would take too much time. As there are a limited specialist eating dis/order services, in order to maximise recruitment from a small pool of potential participants I took the pragmatic decision to use semi-structured interviews to collect data.

As interviewer, I engaged participants as 'co-authors' of the discursive interview (Kvale & Brinkmann, 2009) by inviting them to contribute to the interview schedule (Appendix 5). I did this through two initial questions: firstly asking 'can you tell me a little bit about what interested you about taking part in this research?', and secondly 'what would you like to get out of taking part?' the answers to which I noted. I then returned to each in turn asking the participants to elaborate on their answers, so that these important topics chosen by the participants formed the structure for the initial part of the interview. If after this discussion of the topics important to the participant any of the major topics on my interview schedule (Appendix 5) had not been covered, I then returned to the interview schedule for the remainder of the interview.

2.6. Participants

Participants were nine mental health therapists working in a number of NHS-provided specialist eating dis/order services, across London. The services

included child and adolescent mental health services and adult mental health services.

2.2.1. Sample size

In terms of sample size, Richie, Lewis, and Elam (2003) outline a number of factors that should be taken into account. According to their criteria the sample size of this study does not need to be large, as eating dis/order therapists are quite a homogeneous population; the population size is small; and there are limited resources such as time available. Furthermore, discourse analysis is more interested in the way language is used rather than the quantity of participants (Potter & Wetherell 1987). Morse (1994) suggests that at least six participants are needed for consensus of data content to be achieved. My initial sample comprised nine participants recruited for interview, which was considered reasonable given the small pool of potential participants and limited timeframe.

2.2.1. Demographics

See Appendix 4 for the demographic profile form. Ages were collected as ranges to protect anonymity. Five participants were aged from 26 to 35 years, three from 36 to 45 years, and one from 45 to 55 years. Eight participants were female and one was male. Six participants identified as White British and three identified as from 'any other white background' apart from British or Irish. All participants spoke English.

Eight participants were from clinical psychology and one was a counselling psychology background. Participants' number of years since qualification in clinical or counselling psychology ranged from none (two trainees, not yet qualified) to 10 years, with a mean of 4.1 years. The length of time participants had been working in the field of eating dis/orders ranged from one to 13 years, with a mean of 5.2 years.

2.2.1. Inclusion Criteria

Due to the exploratory nature of the study, inclusion criteria at recruitment included as broad a sample as possible. However, as this thesis contributes to a professional doctorate in clinical psychology my recruitment targeted, and the final sample mostly represented, clinical psychologists. In the eating dis/order unit there is often little distinction between clinical, counselling and family therapy professionals in terms of who does therapy, runs groups, and supervises whom. Thus, the constructions of bodies of all members of the team could be relevant. Medical professions (nurses, psychiatrists) were excluded for the purposes of this research in order to focus on 'talking' therapists and ensure the sample was not too heterogeneous.

Participants' included both trainee and qualified clinical psychologists and counselling psychologists. Trainees were included as often those who are new to a service are the most able to reflect on similarities and differences with other services and specialities. Furthermore, it provides a spectrum of experience within participants. Finally, the literature in eating dis/orders suggests that the impact is most noticeable when clinicians initially begin working in the field (C. S. Warren et al., 2009).

Participants were given the choice of conducting the interview wherever was most convenient for them, at their workplace, at University of East London or another site of their choice. The majority of participants chose to be interviewed at their place of work, with two requesting they be interviewed at home.

The analysis comprised single interviews with nine participants, which produced over fourteen hours of interview material.

2.2.1. Recruitment

The study recruited nine participants utilising the snowball method (Salganik & Heckathorn, 2004). As I have worked in a number of eating dis/order services

I contacted eating dis/order clinicians known to me, asking them to participate and pass on the study details to others who met the inclusion criteria.

Progress on recruitment was slow, however by the time I finished recruiting I had received 17 requests to participate, only nine of which I was able to follow up due to time constraints.

Initial recruitment material included email contact details. When potential participants got in contact I replied briefly explaining the purpose of the research and attaching the information sheet and sample consent form (Appendices 2 and 3). Follow up email contact answered any questions, confirmed their willingness to participate, and arranged an interview. An estimated interview duration of 90 minutes was given. An informal telephone call was offered and taken up by some participants.

2.7. Data collection procedures

Semi-structured interviews ranged in length, from 34 minutes to 1 hour 13 minutes (average approximately 48 minutes). Length of interview was negotiated at the start. Before beginning the interview, participants were asked to sign a consent form and given the opportunity to ask questions about the research.

The interview schedule was collaboratively developed with my director of studies, and slightly amended after the first interview (see Appendix 5). Questions were developed from existing literature, and aimed to explore participants' talk of their own body and how bodies are talked about in the context of eating dis/order services. The interviews were audio-recorded using two digital recorders.

In practice, I was an active participant within the interview and assumed a conversational style following Potter and Wetherell (1987). I did not stick strictly to the schedule, rather responding to participants with further questions

and encouraging participants to elaborate. I aimed to remain cognisant of the interview as a dialogue and influences on the talk such as potential discourses, our respective relational styles and ways of speaking, and the ways in which we both positioned ourselves. An attempt was made to utilise simple language and not assume particular professional knowledge or stance (Patel, 1999).

At the end, participants were thanked and asked how they had found the interview. Exploring experiences, some participants reported finding parts of the interview uncomfortable but none reported being distressed. I acknowledged and validated their experiences. None of the participants took up the offer of further information about locally available support.

2.8. Transcription

All interviews were transcribed verbatim from audio digital data. All names and identifiers were changed or removed during transcription for anonymity. Participant identification was by pseudonym, the names chosen by each participant themselves at the beginning of the interview. As this study was not focussed on the details of speech but on broader 'global' discursive constructions, a simplified transcription convention previously used in FDA was utilised as per Malson (1998), adapted from Potter and Wetherell (1987).

2.9. Foucauldian Discourse Analysis (FDA)

There is no formal set of rules for conducting an FDA. The analysis was an iterative process guided primarily by Arribas-Ayllon and Walkerdine (2008) and my director of studies, but also drawing inspiration from Willig's (2008) six stages for discourse analysis. From this I created my own set of flexible

analytic guidelines (see Appendix 7). These guidelines were reflexively updated through the analytic process.

2.2.1. Reading

Preliminary analysis involved reading and re-reading the printed transcripts. Initially tapes were listened to alongside to check accuracy. I made written notes on the transcripts and in my reflexive journal noting points of interest. As an initial 'gathering of clues' (Rose, 1979) to understand how eating dis/order services are engaged in the constitution of the therapists' body, I looked to the reasons my participants gave for participating. Prominent topics, themes and issues were recorded.

2.2.1. Analysis

I again read and re-read the printed transcripts using my analytic guidelines for an FDA (Appendix 7) consisting of four analytic foci which mapped onto my research questions: *problematizations*, *technologies*, *subject positions* and *subjectification*. In practice, I went through the transcripts multiple times, mostly asking questions of the text that focussed one analytic foci at a time. Attending to *problematizations*, I read the texts and identified what the objects, events and experiences were that were being constructed in the participants' talk. From these, major 'discursive objects' were identified, which seemed to account well for the constellation of constructions. I attended to the specificities of participant's talk, and to similarities and differences in how particular discursive objects were constructed (Malson et al 2004). Once I had been through these stages I re-read the transcripts and purposefully sought out disconfirmatory instances (Arribas-Ayllon & Walkerdine, 2008). See Appendix 9 for my initial visual representation following this initial paper process.

In order to make the data more manageable I then used NVivo 11.3.2 to systematically code the transcripts guided by the initial paper analysis. Codes were then aggregated in NVivo into broader problematizations, discourses,

technologies, subject positions and subjectivities. Comparisons of coding were used to further augment credibility of the findings and triangulate perspectives developing constructions. Analysis was examined in repeated meetings with the thesis supervisor who had read the transcripts, and these discussions guided the process of analysis. The paper transcripts were then engaged with again informed by the NVivo analysis. I stayed as close to the words of the text as possible in order to ensure engagement with the data was not simply filtered through the lens of my own experiences and expectations. I will consider issues of reflexivity below.

The final aspect of the analysis occurred through the write-up certain extracts were selected over others, and the writing process clarified my formulations.

2.10. Reflexivity

Reflexivity is the awareness of the researcher's contribution to the construction of meaning throughout the research process, with acknowledgement of the impossibility of removing oneself from one's subject matter. I recognise that by focussing on the therapist's body in this research, I am myself problematising the therapist's body.

I acknowledge this thesis as a co-construction of knowledge production and sense making between participants and myself. My interests, assumptions, biases, contexts and physicality will have influenced the process of research, and interact with those of participants when collecting data (Billig, 1997).

I will introduce my embodied self and my context in order to facilitate the reader's understanding of my position as researcher, so this can be taken into account while reading this thesis. I identify as a 'White' woman, British, and my voice speaks to my middle class English social location. As a trainee clinical psychologist at the University of East London (UEL), I take a critical and feminist position, though my feminism long predates my time at UEL.

Thinking of my body, one of the most distinctive parts of my embodiment is my height, which for many years (and still occasionally) meant I did not quite know where my limbs ended. I have no lived experience of what is called an eating dis/order, though it is often assumed that I do due to my thin body.

My interest in the therapist's body began whilst I was a research worker at a eating dis/orders service, where my thin body was talked about, and I felt became problematic, particularly in supervision. I was informed that clients who had seen me in the corridor were finding my ankles 'triggering', and that in order to work therapeutically in the service I would need to gain weight and wear long sleeves and trousers to conceal my limbs. Early on in my career, and interested in working therapeutically with embodied distress, I became anxious and troubled that my body, something I felt I had little power to change, could be so upsetting to others and preclude me from working in the area. I found myself conflicted, as I understood that the service was trying to challenge the thin ideal, and also felt that a range of bodies should be able to be reflected in the service. I noticed that shame got in the way of being able to explore further with my supervisor. I was curious about my body becoming so problematic in this field, as my body has not been raised in other professional contexts. When I searched the literature I found very little on the subject of the therapist's body in eating dis/orders. What was written did not provide critical, rich or alternative ways of talking about the therapist's body. Interested by this gap in the literature, I chose to conduct qualitative research into constructions of the therapist's body in eating dis/orders for my doctoral thesis.

I was on an elective final placement in an adolescent eating dis/order service while collecting my data. In interviews I found I took an insider-researcher position, aligning myself with my participants and sharing my own experiences towards the end of the interview. This position was valuable for establishing alliance, addressing the power differential, and maintaining authenticity and reflexivity throughout the research (Bonner & Tolhurst, 2002).

A reflexive journal was kept through each stage of the research process. Please see below for an example entry.

Extract from reflexive journal, written following an interview

“I was struck by the passion with which she spoke about this (research) being important. However, conversations exploring this seemed to be difficult. She talked about taboos but found it difficult to provide evidence or examples for why clinicians’ bodies are taboo, ‘difficult to articulate’. However, the taboo seemed present and visible in physicality, for example getting stuck on words, tense, twitches in face, becoming flushed at times. I was aware of my own body, that I was worrying how visibly thin I was to her, and I wondered if she was being careful not to offend me when talking about thinness in therapists. It felt like a lively discussion but also very careful, certain areas got stuck and did not feel like it was safe enough to speak, particularly personal experience. There was lots of discussion of anonymity. There was not much reference to gender, but it was often implicit in the talk.”

This chapter has presented my methodology, the next will guide the reader through the results of my analysis.

CHAPTER 3 - ANALYSIS AND DISCUSSION

This chapter presents my analysis of how therapists who work in eating dis/orders talk about their own body. The structure is organised around constructions of the therapist's body identified in the participants' talk. The therapist's body was problematised in complex, contradictory and dualistic ways in relation to: firstly, the work; secondly, talking; thirdly, visibility and watching; and fourthly, subject positions of healthy and pathologised professional. These sections are interlinked and the separation is, of course, artificial; as the analysis is itself a construction informed by my own context.

To provide context I include longer extracts against my contributions so that readers can discern for themselves the validity of my conclusions (Yardley, 2000). I have chosen extracts that illustrate each construction particularly well and represent the broader sample. Appendix 10 shows a diagram of the analysis, visually representing the different constructions of the therapist's body and detailing the representation of the sample against each construction.

I am not claiming that participants are intentionally constructing the objects below, or that the discourses are attributable to them. Rather, from a discourse analytic perspective through their talk we can see the discursive resources available to them.

3.1. THE THERAPIST'S BODY AND THE WORK

The talk rendered the therapist's body problematic in relation to the work.

3.1.1. The therapist's body as impacted by the work

Walkerdine (1986) asserts that discourses have powerful, 'real' material effects on embodied subjects. The following extracts demonstrate a multitude of ways in which the therapist's body is constructed as impacted, such as: greater awareness of bodies; changes in body practises such as eating, weighing, dressing (e.g. **Rachel**: 550-556); and how the therapist feeds her children (**Angela**: 174-182).

Discourses sustaining these constructions include: biomedical discourses of diagnosis, which encourage classification of bodies as either healthy or pathologised; cognitive-behavioural and dietetic discourses of what represents 'healthy' eating; discourses attributed to clients such as idealisation of thinness and control over the body; and psychodynamic discourses of countertransference whereby changes in the therapist's body enrich understandings of therapy.

Participants' accounts frequently constructed the impact of the work as inevitable: particularly when the therapist first began working in the field, but then fading over time.

3.1.1.1. 'It becomes part of your own thinking': The work as increasing awareness of bodies and food

Accounts constructed eating dis/order work as immersion in talk about the body (**Frankie**: 44). Talk of bodies was constituted as coming from two directions: on the one hand discourses supposedly attributed to clients, and on the other the discourses of eating dis/order services. Participants constructed the work with clients as being 'bombarded' by values that idealise thinness, denigrate fat, and produce body dissatisfaction, distress and preoccupation. Further, the work involved submersion in discourses of meal plans and BMI. These seemingly conflicting discourses were constructed as becoming part of the therapist's 'own thinking' (e.g. **Angela**: 256-257).

In the extract below, the work is constructed as impacting on the therapist's consciousness and body practices.

Extract 1

Anna: It kind of becomes, it can become part of your own thinking in some ways about food and about body shape and about, you know, about what kind of calories are ok and what aren't (...) it goes in two ways for me. You know, I get really hungry and I just want to eat and think actually, do you know what, it's fine to eat and just eat, and think maybe that was a bit much. And at other times I'm possibly more aware of, kind of, nutrition or calorie content. (**Anna:** 56-61)

Anna constructs the impact as a duality that can go '*one of two* (negative) *ways*'. Firstly, by reacting against restriction through feeling '*really hungry*' and '*it's fine to eat*'. There is a hint at not being in control, eating '*a bit much*'. Hunger is examined further in 3.1.1.4. Secondly, there is increased control, observation and regulation of bodily practices: '*what kind of calories are ok and what aren't*'. This construction parallels previous literature, for example Warren et al. (2009) constructed increased awareness of eating and bodies as 'a hazard of the job'.

The extract below constructs increased judgement of bodies.

Extract 2

Anna: I found *myself* really noticing people's, kind of, people who were overweight. I found myself really, that, kind of, coming into my consciousness much more than it had done before. I was very aware of, like seeing people and having really unpleasant judgements that I wouldn't have had before I had to work with those kids. //M: Such / Yeah, that's a bit that's not very, you know, "that's pretty disgusting" or, you know, "do some exercise". (**Anna:** 176-183)

This constructs the work as increasing '*consciousness*' and '*awareness*' of '*other people's overweight*'. Overweight is constituted as '*disgusting*' and morally bad, a source of fear and revulsion (Orbach, 1993). Normalising judgements ('*do some exercise*') act to categorise individuals as normal/not normal and discipline those who fall outside the 'normal BMI'. In order to manage one's moral location, not be '*overweight*', body management practices such as '*exercise*' become central to the formation and maintenance of the self. The moral value placed on thinness and control over the denigrated body are made possible within a discourse of Cartesian Dualism (Malson & Ussher, 1996). Modern dualistic discourses of overweight and exercise may be preoccupied with the body and its appearance, but little pleasure is derived from embodiment (Bordo, 1997).

It is interesting that these discourses of overweight are attributed to '*those kids*' given a diagnosis of an eating dis/order, as the discourses have much in common with broader societal values. In the last two decades the emergence of the 'global obesity epidemic' as a national and global health priority, with associated public health incitements to weight loss, has resulted in 'body weight' being constructed as a key index of health (Malson, Clarke, & Finn, 2008). Health becomes equated with a particular, normative body size and shape. Through the hegemonisation of 'healthism' and increased pathologisation of 'fatness', discourses supposedly attributed to eating dis/orders become increasingly indistinguishable from the normative values of society.

From this perspective the discourses of the eating dis/orders unit that espouse eating three meals and two snacks a day come to seem 'abnormal'. Eating dis/order therapists are caught between broader Western aspirations of thinness and 'healthy' (restricted) eating, and the local service context that values overturning these ideals. The same discourses that produce the women and girls living with eating dis/orders as problematic, discussed extensively in the critical literature (e.g. Malson, 1998; Malson & Burns, 2009), also act to problematise the therapist's body.

3.1.1.2. The work as impacting the therapist's body and body practices

The therapist's physicality is constructed as impacted by the work. In the extract below Rachel constructs the work as weighing others, which transfers to weighing herself.

Extract 3

Rachel: I started to gain weight and that process was really difficult for me at times, when I was talking a lot about weight and shape in, in sessions. I remember as well because I was going on holiday, I was going to [...], and I was like oh, I don't know if I want to put any more weight on, and it wasn't like *hugely* problematic for me, I wasn't getting upset by it, but I was getting aware of it and I was weighing myself, not all the time but a bit more regularly than I have done before, and I was like, and that lasted like maybe, a month or so and I was like, *what am I doing?* **Martha:** mm/ But I think it was quite interesting because I'd never had that. And then I just was like this is *crazy*, stop. Like, I don't, I don't need to worry about this. I will get back to sixty kilos because that's what I've always been, plus, you don't really need to worry about your weight, you don't, you don't *want* to worry about your weight, and I kind of overcame it quite quickly. (**Rachel:** 147-156)

Rachel constructs gaining weight as problematic: '*I was gaining weight and the process was really difficult for me at times, when I was talking a lot about weight and shape in, in sessions*'. Absent but implicit in this extract is the reasoning as to why gaining weight is difficult or problematic. The work involves engaging with discourses idealising thinness and fear of weight gain. She references an upcoming beach holiday, alluding to the idea of 'beach body' (Jordan, 2007) founded on discourses idealising thinness. Furthermore, the work involves 'weighing people' which turns to weighing herself.

Foucault argues that normalising judgements and detailed examination of the body is one of the technologies of power by which the body is rendered docile (Foucault, 1977). These are the very processes by which the therapist

governs the conduct of women and girls given a diagnosis of an eating dis/order: hierarchical observation (of eating, food diaries), examination (weigh-ins) and normalising judgements (of weight gain and BMI). These disciplinary processes extend to the therapist herself '*I was weighing myself (...) more regularly than I have done before*'. Thus, through self-surveillance and self-examination, the speaker becomes a self-disciplining subject. Weighing can be seen as a 'technology of self', an embodied practice whereby the self is constituted (Foucault, 1988) in order to achieve an idealised form of beauty and control.

At the same time weighing and worrying about weight are constructed as 'crazy' and pathological in the context of biomedical discourses and diagnostic criteria such as fear of weight gain. The exclamation of '*what am I doing?*' serves to emphasise the importance of the professional not engaging with bodily practices considered pathologised. She neither wants to *be* or *do* 'crazy', and seeks to resist pathologising processes of subjectification. Perhaps with a consciousness of this, the account emphasises that the weighing and weight gain were '*not hugely problematic*'.

3.1.1.3. "I remember doing that in the past": The impact of work as initially strong and fading over time

The impact of the work was constructed as strongest when the therapist first begins working in eating dis/orders. Participants new to the work constructed it as more impactful on their body than more experienced therapists who minimised the impact of the work. Below Lily constructs her body as impacted by inpatient work when she first started in the field.

Extract 4

Lily: I remember certainly being in an inpatient setting and eating meals with people who were very severely unwell, being quite aware of what I was eating and feeling that I had to you know, I had to be a good role model so therefore I had to be eating a lot but probably was more than I needed to be eating, at that

time and I think, I remember gaining quite a bit of weight when I first started that work. /**Martha**: umm/ Umm, so yes, I think it did impact in the early days, I think then when I became aware of that and maybe managed to, kind of, regulate it again (...) I've been in it for quite a long time now so, yeah, you do get used to it (laughs) (**Lily**: 54-67)

The work is constructed as impacting on the therapist's body '*in the early days*': '*I remember gaining quite a bit of weight when I first started (inpatient) work*'. She takes up the subject position of '*good role model*', which involves '*eating a lot*', echoed elsewhere in the accounts (e.g. **Olivia**: 92). The work's impact on her body is undesirable, she has now '*managed to regulate it*'. Time is constructed as 'regulating' the impact, or perhaps just awareness: '*you do get used to it*'. The impact of the work on the body becomes normalised.

The extract above explains how level of experience interpellates therapists into subject positions such as the 'experienced therapist', from which the therapist's body can be constructed as no longer impacted by the work. From this position, reflection on the body such as in supervision becomes unnecessary. This contrasts with other published accounts (Burka, 1996; Petrucelli, 2007), where psychodynamic therapists construct their body as becoming *more* relevant with experience, facilitating conversations rather than reducing them.

3.1.1.4. "I'd come out of the session and be ravenous": The work as impacting on therapist's hunger and eating

In the extract below the work is constructed as impacting on the therapist's hunger.

Extract 5

Robin: I noticed when I started working at [the eating dis/orders service], I like, had to eat *all the time*. It was like I *had* to have something to eat between clients. Like, I'd come out of the

session and be, like, *ravenous*, you know. And I mean it was kind of you know when I was with people who were anorexic it was more, you know, I came out so hungry, came out of the sessions. And I noticed with, when I came out of sessions with people with, sort of, binge eating and bulimia I felt very kind of *overwhelmed* very sort of *full*, you know. (**Robin**: 141-147)

In this extract, the therapist's embodiment is presented as directly impacted by being in the presence of the client. These discursive constructions reflect discourses of anorexia ("*ravenous*" or "*hungry*") and bulimia or binge eating ("*overwhelmed*" or "*full*"). The physical states associated with each of these constructions become part of the therapist's own embodiment. Discursive constructions of the therapist's body picking up the client's experience call to mind psychodynamic concepts of countertransference and projective identification. This extract provides little sense of the boundary between therapist and client: the client's emotional and physical experiences are fashioned as indistinguishable from those of the therapist.

This extract below is interesting because it does not draw upon a mind-body dualism discourse. The psychodynamic discourse of transference speaks to embodied physicality, where the therapist's feelings in their body are able to inform them of their client's experience.

Extract 6

Lily: Post qualification a patient of mine was being admitted to a physical health unit because she had been so unwell, and I escorted her to the unit and I remember the evening there and going and buying an extra large MacDonald's meal which I don't think I have ever done in my life. (laughs) And I think it was something about, you know, it was wanting to feed her but feeding myself instead (**Lily**: 61-65)

The extract above constructs the therapist's body practices as altered, she ate an '*extra large McDonald's meal which I don't think I have ever done in my*

life'. Drawing on discourses of countertransference the gravitation to a large calorific meal, frowned upon within healthism discourses, is constructed as '*wanting to feed*' her '*patient*'. I suggest this alludes to impact of the work on subjectivity, the empathy and distress about her '*patient*' being both admitted and '*so unwell*'.

Within this embodied psychodynamic discourse changes in the therapist's body and practices are constructed as less distressing, less '*crazy*' (**Rachel**: 154) and rather are meaningful. The body becomes a resource that promotes empathy, and enriches the work. Discourses of projective identification and transference allow new ways-of-seeing and being whereby impact on the therapist's physicality is rendered understandable and meaningful.

3.1.1.5. "I was quite consciously accepting my body": The therapist's experience of their body as positively impacted

A number of participants constructed their body and embodiment as positively impacted by the work, becoming more accepting of their body.

Extract 7

Rachel: In my first job I worked with really severe, chronic anorexia cases, people that, we were treating, they were that end of the spectrum, these people's lives had been absolutely destroyed by being focused on weight and shape. And I was like, so I actively, and it worked you know, I was really wouldn't allow myself to worry about it and I didn't, I just thought this is not worth my time /**Martha**: mm/ and I didn't, I was quite consciously accepting my body around that time. (**Rachel**: 96-101)

This extract constructs the impact of seeing '*people's lives absolutely destroyed by being focused on weight and shape*' on her body at the time. She construes the impact as positive, as making her '*consciously accepting*' of her body, rejecting normative discontent and the discourse of idealisation of thinness.

This could be considered a form of resistance to the dominant cultural discourses of female beauty. As Foucault asserts, 'where there is power, there is resistance' (Foucault, 1979, p. 95). We can see resistance to cultural preoccupation with idealisation of thinness and denigration of fat in this account and others (e.g. **Lily**: 433-442), where the visible crystallisation of the destructive consequences of these discourses allows participants to take a different position, such as '*consciously accepting*'. These ideas seem to draw on classic feminist discourses such as '*anti-diet*' (**Lily**: 434)(Orbach, 1978).

The accounts also problematised the therapist's body through it impacting on the work, below.

3.1.2. The therapist's body as impacting on the work

The therapist's body was constructed as impacting on the work in multiple ways. Firstly relating to clients: as modelling, as important and meaningful to clients, as 'triggering', and as comparison and competition. Secondly, in relation to their professional competence, as important for self-care and being 'robust', as a source of empathy or not understanding the client, and as something threatening therapist objectivity.

Below, Frankie describes how it would be "naïve" to think that the therapists' body does not impact therapy.

Extract 8

Martha: I'm just interested to know what you mean by *it's not talked about openly in teams* but you know it's thought about. How do you know it's thought about?

Frankie: '*Cos I think about it* (laughs) and, and I guess, just informally as well with, you know, with a colleague you know, umm, you may have a discussion or kind of a comment or something like that. Umm, but I think, you know, we work in, in eating disorders you are, you are working with people and talking and thinking

about shape and weight all day long so, umm, you'd be naïve to think that your own body shape and how you relate to that is, is not, doesn't impact. (**Frankie**: 100-110)

In the excerpt above the speaker contrasts constructions of the eating dis/orders team's lack of formal reflection on the therapist's body (*'it's not talked about in teams'*) with a claim to knowledge that therapist's bodies *are* thought about. This claim is evidenced in three ways: firstly, by emphasising that she gives her body thought (*'cos I think about it*); secondly, through *informal* conversations *'with colleagues'*; and finally, through playing a 'truth game' by using the word *'naïve'*. By emphasising that in the context of eating dis/orders *'you are talking and thinking about shape and weight all day long'* and use of the word *'naïve'*, Frankie makes a claim that it is self-evident that the therapist's body would impact on the work in eating dis/orders. Thus, despite the apparent silence on the subject, the therapist's body is constructed as inevitably both relevant and impacting on the work.

3.1.2.1. The therapist's body as problematic when it changes

Participant's accounts constructed their bodies as coming into focus at times of visible change. Interestingly, many of the changes were steeped in concerns of gender, such as menopause (e.g. **Angela**: 219) and pregnancy (e.g. **Lily**: 193). In the extract below, a therapist constructs her body in the context of weight loss for a wedding.

Extract 9

Anna: I lost quite a lot before the wedding and I did wonder if they were noticing, 'cos everyone else around me was noticing, and none of them commented. But I did wonder whether they were noticing. What sense they were making of it? (...) But it was interesting, thinking about, umm, how people, you know. Just kind of making sense of, because I was trying to lose weight because I didn't want to walk in to everybody that I know, seeing me feeling like a bit of a fatty. (...) We might work really hard

with kids to be thinking about how many other things contribute to their value and worth and all the rest of it. But actually when it comes to days like that, you know there is something really important about looking the way that you want to look and not having people judging you for, you know, not having lost enough weight (**Anna:** 85-99)

Weight loss in the therapist is constructed as '*healthy*', 'fine and important', especially '*when it comes to days like that*', a woman's wedding day. Within wedding discourses values of female beauty come out in full force. The bride is disciplined through the gaze (Foucault, 2012) and normalising judgements, whether she has '*lost enough weight*' or is '*a bit of a fatty*'. This extract emphasises just how powerful societal discourses valuing women on beauty are.

3.1.2.2. Contesting idealisation of thinness

Though no accounts mentioned the word feminism, feminist and critical discourses could be seen. Experience with eating distress was constructed as facilitating critique and deconstruction of societal standards of beauty through exposure to the distress they produce, such as in the extract below.

Extract 10

Olivia: I'm not sure doing the work clinically has had much of an effect on the way I think about other people's bodies talk about other people's bodies (.) um (.) I think my own personal experiences of having an eating disorder have done that really /M: mm/ um (.) for example I've always been really angry and passionately angry (laughing) about the dieting industry and about western ideals of body image /M: mm/ and about culture of beauty and the i- i- thinness ideal. (**Olivia:** 348-353)

Above, '*personal experiences of having an eating dis/order*' are constructed as producing resistance to dominant discourses of '*Western ideals of body*

image ... culture of beauty and the thinness ideal. This '*passionate anger*' is framed as inoculating against damaging cultural discourses and positively impact the therapist's sense of embodiment: "*I almost feel immune to this shit ...I'm so over feeling crap about myself*" (**Olivia**: 490-491).

3.2. THE THERAPIST'S BODY AS VISIBLE AND WATCHED

The therapist's body was constructed as visible and watched by clients, colleagues, and the therapists themselves. I will link this construction of the body as watched to technologies of power and self.

3.2.1. 'Visibly underweight': The therapist's body as visible

In the extract below, the therapist's body is constructed as a visible signifier of anorexia.

Extract 11

Olivia: I had a colleague I worked with a couple of years ago who was very visibly underweight significantly so and there was, people talked /**Martha**: Mm (.) and what did people say /**Olivia**: Um I suppose they would raise eyebrows and sort of say that they thought that she was ill and not well and I wouldn't want her treating my child /**M**: mm/ [...] what kind of role model is that /**M**: mm/ I wouldn't want an anorexic doctor treating my child with anorexia (**Olivia**: 403-407)

Anorexia is constructed as '*visible*', written on the therapist's body through being '*visibly significantly underweight*'. Within the very particular context of the eating dis/order unit, 'psychiatric diagnosis is assumed to be visible. The simultaneously expert and pathologised subject position of the '*anorexic doctor*' is constructed is problematised as almost dangerous '*I wouldn't want an anorexic doctor treating my child*'.

Anorexia has been characterised as both *Valued and Visible* (Schmidt & Treasure, 2006), which seem to act to make it particularly problematic when combined with the subject position of expert professional. Anorexia as *valued*, or 'ego-syntonic', has often been given as the reason for poor recovery rates within dominant literature, the implication being that the '*anorexic doctor*' might not want to recover, and these values might be transferred to the client '*what kind of role model is that?*' The professional is disciplined through observation and normalising judgements.

However, this construction assumes all eating dis/orders are open to literal, visual interpretation. The presence of thin bodies is troublesome in a eating dis/orders unit founded on simplistic 'objective' diagnostic criteria. The multiple expressions of eating and body distress that are encompassed in eating dis/orders are often subsumed under anorexia: anorexia remains the flagship of eating dis/order literature and research despite being much less prevalent than, for example, the more visually ambiguous or invisible bulimia. Disciplining fellow 'thin' clinicians through observation and normalising comments may then be paradoxical. As highlighted in a previous FDA of an eating dis/orders unit (Surtees, 2009) while a visibly 'thin' clinician may fall below a 'healthy' BMI of 19.5 may be pathologised despite not having an eating dis/order, a clinician who engages in various 'technologies of self' such as purging but whose BMI falls in the 'healthy range' remains largely unproblematic within the team (see also Squire, 2003).

3.2.2. The therapist's body as watched

In the extract below, Anna constructs her weight loss as something watched, noticed and commented on by the team.

Extract 12

Anna: There was definitely something about people kind of watching and, and noticing and (.)

Martha: And how, how did you know they were watching and noticing?

Anna: ‘Cos they were *saying* (laughter). Yeah they were, umm, pretty explicit (**Anna:** 105-112)

Joint technologies of power, processes of normalisation and surveillance (*‘watching’ and ‘noticing’*), can be seen to govern the therapist’s conduct.

3.2.3. Technologies of power and self

3.2.3.1. Surveillance and panopticonism

To deepen my understanding of the implications of visibility and being watched I returned to Foucault. In *Discipline and Punish*, Foucault (1977). He argues that from the eighteenth century onwards there was a shift in the focus of power from domination through forced servitude and corporal punishment, to a new subtle form of power that functioned through detailed observation and examination of the body.

“The success of disciplinary power derives no doubt from the use of simple instruments; hierarchical observation, normalising judgement and their combination in a procedure that is specific to it, the examination.” (Foucault, 1977, p170)

Bodies were disciplined through a new “micro-physics of power” and the “political anatomy of detail”, involving surveillance and the accumulation of detailed knowledge assessing the individual (Foucault 1977, p 139). This infinitesimally subtle control acts to render human bodies as disciplined and “docile”. Through docile bodies, the medieval power of coercion was no longer necessary, as ‘a body is docile that may be subjected, used, transformed and improved.’ (Foucault, 1977, p. 136).

In Foucault’s earlier writings, disciplinary practices and techniques operate by means of internalised self-surveillance, exemplified in Bentham’s panopticon, such that the external sanctions or forms of control were no longer necessary to bring the subject into line (Foucault, 1977). He asserts that modern

individuality is produced through observation and detailed examination of the body and the self (Foucault, 1977). The production of the individual subject of the thin/anorexic woman has been argued to be an exemplar of this process (Malson, 1998; Malson & Ussher, 1999).

3.2.3.2. 'Someone might raise an eyebrow': The normalising gaze

Foucault asserts that marginalised groups are constituted and controlled by observation and normalising judgements, for example criminals (Foucault, 1977) and those judged sexually 'abnormal' such as 'homosexuals' (Foucault, 1979). However disciplinary power is also extended to non-marginalised groups (Foucault, 1977), and evident in the accounts of these therapists who occupy the 'expert position'. Norms are defined through observation, the 'gaze', and social categorisation of individuals in order to distinguish the 'normal' from the 'abnormal'.

Eckerman (2009) argues that in contemporary times there is not one unified 'gaze' surveying and regulating practice. "The normalising gaze' that Foucault proposes to explain the objectification of women's bodies since the seventeenth century transmogrifies into a plethora of often contradictory 'normalising gazes' for young women in the twenty-first century.' (E. Eckermann, 2009, p. 11). Thus, there are multiple 'normalising gazes' focused upon the therapist's body, from clients, colleagues, themselves, and society at large.

3.2.3.3. *Practice what you preach*: self-disciplining subjects

These technologies of power of the eating dis/orders unit, of observation, examination and normalisation, can also be seen to be technologies of self. In the extract below, the speaker constructs her bodily practices as impacted upon by her new knowledges acquired in the eating dis/orders unit.

Extract 13

Robin: When you start working in an eating disorder clinic you become very versed on what you should be eating, what you shouldn't be eating, you know, timings, all that kind of thing. So I was sort of looking at my intake and I was a bit like, oh ok, so actually it's a really good idea to have, you know, three meals and two snacks a day and like I was doing that anyway but now I could kind of understand why. And I kind of like can think about, you know, what I'm eating and, you know and sometimes I would be out and I'd be like aw, I really want like a pizza or a burger or whatever, and I'd be like aw, but I shouldn't have that. And I'd be like no, fuck it like, I should, you know. And so I'd kind of like, use some of the stuff I was doing with my clients, like, on myself, you know, so I was sort of um (.) um yeah I guess I kind of, I almost felt like I had to sort of, take myself through the process of what it would be like for them, or what it's like for them to come to the clinic, you know, and, kind of, had to make sure that I was also testing, you know, I didn't want to preach what I didn't practice (**Robin:** 141-164)

The work of the therapist is constructed as a prescribed set of rules or norms '*what you should be eating, what you shouldn't be eating, you know, timings*'. This draws on cognitive-behavioural and dietetic discourses of what represents 'healthy' eating: '*three meals and two snacks a day*'. From within these professional biomedical discourses the therapist is positioned as expert, governing and normalising behaviour 'practice' through '*preaching*' to the passive client/patient. These practices are then applied to the therapist themselves: thus the speaker does not want to 'preach what I didn't practice', and so she becomes a self-disciplining subject.

3.2.4. Body as image

Much of the participants' talk constructed the body primarily in terms of body image. I was curious that, despite making no mention of body image in my

participant information sheet or initial questions, many participants reduced my research to that of clinicians' body image.

In the excerpt below, Olivia gives an account of this research being about therapists' body image:

Extract 14

Martha: First of all I was wondering what interested you in taking part in this research

Olivia: Well It's quite relevant to me I suppose in that I'm really interested in working with eating disorders and I'm about to qualify from training and I'm going into an eating disorder job (.) I think it's a really relevant topic no one ever really talks about body image (and) clinicians' own experiences of it, it's often just sort of there in the room (**Olivia:** 19-25)

In this extract the therapist's body is synonymous with '*body image*', and it is not the therapist's physical body but their '*body image*' that is present '*in the room*'. Within positivist literature the term '*body image*' refers to the mental representation of what one's own body looks like. It is concerned with the aesthetics or attractiveness of the body.

The prevalence of '*body image*' within eating dis/orders literature has been criticised. Probyn (2009) asserts that the '*body image discourse*', where eating dis/orders are attributed to media images of women, is now a reified and prevalent form of knowledge from healthcare services to lay accounts. Probyn (2009) argues that the fascination with '*body image*' renders the body as '*static*', an image without embodiment. Reducing the body to '*image*' or appearance warrants surveillance of the body, objectification, and comparison with other idealised bodies, and obscures other aspects of embodiment such as feelings, emotions, and sense of inhabiting flesh. The body is detached from the social forces that mould how it is made to feel.

In this way, the discursive construction of 'body image' is dependent upon the discourse of mind-body dualism so prevalent in Western society. It obscures the full range of embodied experiences, decontextualises the body, and reduces it to visible observable image. Self-objectification has been implicated in eating dis/orders (Calogero, Davis, & Thompson, 2005). Thus, viewing the body as image or object may reproduce the very technologies thought to produce eating dis/orders in the first place. I will now consider the therapist's body in relation to talking.

3.3. THE THERAPIST'S BODY AS BOTH TALKED ABOUT AND SILENCED

The therapist's body was paradoxically constructed as both talked about and not talked about.

3.3.1. '*The elephant in the room*': The therapist's body as not talked about

Wanting an opportunity to talk about their own experiences of their body was frequently given as a reason for taking part in this research. Accounts construed different aspects of the therapists' body as absent: body image (e.g. **Olivia**: 24-25); concerns about food, eating, weight and shape; diet (e.g. **Olivia**: 73-74); how we feel in our own skin (**Olivia**: 405-406); also being subject to the thin ideal (**Olivia**: 599-600); and personal history of eating dis/order.

Thus, the therapist's body was constructed as problematic through being simultaneously of interest and silenced. This is demonstrated in the extract below about a conversation with a supervisor about "*the elephant in the room*".

Extract 15

Olivia: She said y'know and I've worked with colleagues before (.) one who was very visibly underweight and she said it did feel like the elephant in the room /M: mm/ I said why don't people talk about this (.) /M: mm/ um (.) and she couldn't really answer (**Olivia:** 426-427)

In the above extract 'visibly underweight' colleagues are constructed as 'the elephant in the room', noticed by everyone but mentioned by no-one. The reason for the unspeakableness of the therapist's body the supervisor 'couldn't really answer', it is unknown or difficult to articulate. However, ironically this not-talking was communicated in a conversation about bodies in supervision. The therapist's body is conflictingly constructed as talked about and not talked about.

3.3.2. Bodies and sex: 'A proliferation of discourses'

The extract below constructs the sexuality of the body as an inhibitor of body talk.

Extract 16

Luke: Maybe another inhibitor to some of these conversations is, is, sex, really that kind of, checking out other people's bodies and thinking about other people's bodies and kind of, is, yeah, has that dimension (**Luke:** 543-545)

The parallel Luke draws between bodies and the taboo subject of sex is an interesting one, given Foucault's (1979) repressive hypothesis of sexuality. Foucault posits received wisdom is that sex is governed through repression: that 'modern prudishness' was able to ensure 'censorship' and that 'one did not speak of sex' (Foucault, 1979, p. 17). However, Foucault (1979) turns received wisdom that on its head, arguing that modern power governing sexuality functions primarily through a proliferation of discourses:

“More important was the multiplication of discourses concerning sex in the field of exercise of power itself: an institutional incitement to speak about it, and to do so more and more; a determination on the part of the agencies of power to hear it spoken about, and to cause it to speak through explicit articulation and endlessly accumulated detail.”

(Foucault, 1979, p18)

Using Foucault’s analysis of sexuality, we can see that the construction within participants talk of bodies as taboo in the eating dis/order unit is accompanied by a proliferation of discourses about the body and bodily practices.

‘This was not a plain and simple imposition of silence. Rather, it was a new regime of discourses. Not any less was said about it, on the contrary. But *things were said in a different way; it was different people who said them, from different points of view, and in order to obtain different results.*’ (Foucault, 1976, p27, my emphasis)

A similar multiplication of discourses alongside an ‘imposition of silence’ can be seen for talk of therapist’s bodies in the eating dis/orders unit.

Many participants constructed therapists’ bodies as both talked about and silenced.

Extract 17

Luke: It is a really interesting area that isn’t spoken about openly. /M: umm/ Though I think there are, quite often, some, I have heard quite a lot of people make comments about (laughs) body shapes of therapists in the eating disorder team, so I’ve heard people kind of, comment on, gosh well, that person’s very slim but they work with eating disorders. Umm, yeah, I don’t think it’s spoken about much /M: umm/ in teams but I think it is something that people do think about. (Luke: 12-17)

Luke highlights how clinicians' bodies are not 'spoken about openly', contrasting the absence of overt discussion of therapists' bodies ('I don't think its spoken about much') with a concomitant proliferation of covert references to therapists bodies in the form of 'something that people do think about' and 'comments'.

3.3.2.1. The therapist's body as private

One way that the body was produced as difficult to talk about as a private matter. This is linked to the idea of "taboo", where body talk is prohibited. In the extracts below Luke describes the body as an impolite subject, and frames his experience of the interview as 'liberating':

Extract 18

Martha: You felt liberated which is a really interesting word and I was just wondering, what, liberated from what? If, if

Luke: Umm, I guess from [being] all polite and not talking about difficult things (...) Bodies and stuff, is one of those things that, particularly British people, don't like talking about (**Luke:** 495-505)

Thus Luke constructs bodies as problematic and '*difficult*' to talk about, an impolite subject that people '*don't like talking about*', particularly within British culture. The impact of talking openly about bodies is '*liberating*' for his subjectivity, not talking is by implication an oppression or subjugation associated with shame.

The construction of bodies as private can be seen elsewhere in the texts, for example Frankie accounts for therapists finding it difficult to talk about their bodies in this interview through constructing body talk as a personal, private matter. This is echoed Petrucelli (2007), who asks whether the therapist is giving up their sense of privacy when they allow their body to be talked about. Other accounts framed our conversations about their body as uncomfortable:

Extract 19

Frankie: It's quite personal isn't it, /M: umm/ although at the same time we are expecting our, our patients to, to, to be that personal with us. /M: umm/ So, why we find it so difficult to do with ourselves, /M: umm/ I don't know. Yeah, I don't know, people may feel judged or criticised (**Frankie**, 342-350)

Body talk is constituted here as 'personal', and outside the sphere of usual professional discussion. Furthermore to talk about your body is to open yourself to being 'judged or criticised'. This reflects the dominance of the societal construction of a woman's body as a proxy for her worth and success, so that any talk of her body becomes an evaluation of her worth. It is interesting to note that only a male participant constructed body talk as 'liberating'. At the intersection of dominant societal discourses that dictate a women's worth is based primarily in her body, professional discourses act to protect clinicians from critique. 'We' professionals and '*patients*' are differentially positioned within the power of biomedical discourses: those in subject position of 'patient' are expected to be 'judged and criticised'; but professional bodies are off-limits.

3.3.2.2. 'A bit of a luxury': The therapist's body as not necessary to talk about

Some accounts constructed therapist's bodies as unnecessary to talk about, through framing them as not relevant. Thus participants managed their moral location within their social interaction in this interview, as it becomes justified to not talk about the body.

In the extract below, talking about the therapist's body in supervision is constructed as not necessary:

Extract 20

Martha: Do you think generally, regardless of how someone looks, conversations should be had about embodiment, about how you feel about your own body?

Angela: Um knowing the sort of reality of pressure of clinical work, it only probably gets confined to kind of social conversations you have outside of work with your colleagues or conversations you have informally, um, and then it would only be something you'd bring up in supervision if it was really impacting on your clinical work (...) I think your question was whether or not it should be discussed I think it, it should if it impacts on the work and it should if there's space with your colleagues to think about it because it's interesting (laughing) you know? /**Martha:** mm/ and it has an impact on the way you think about your patients to a certain extent

Martha: Do you feel that there's space made in supervision for those conversations to come up?

Angela: No, no not really and you know the pressures of the work mean that would be just a bit of a luxury (**Angela:** 304-338)

There are multiple constructions of the therapist's body in this excerpt. The account manages her moral location of not talking about her embodiment within the context of our interaction: my leading questions and the explicit aims of the research on how therapists talk about their bodies. Having a space to reflect on your own body and embodiment in the context of your work is framed as an interesting idea in principle (*'it should if there's space with your colleagues to think about it because it's interesting'*), but not particularly relevant in practice: *'it would only be something, you'd bring up in supervision if it was really impacting on your clinical work'*. This excerpt constructs the therapist's body as something *'interesting'* that is talked about in social conversations. However, reflecting on the body and embodiment is a *'luxury'* within the context of *'the reality of the pressure of clinical work'* and thus is not workable in practice. Reflective practice as *'luxury'* that cannot be afforded is a common discourse in healthcare (e.g. Thompson, 2008). Thus, the conditions of possibility that render the therapist's body not talked about

include the current political and economic climate of underfunding and limited resources within the NHS.

3.3.3. Negotiating talk in supervision

There was much talk of whether body talk should be part of supervision, and if so who should bring it up: supervisor or supervisee. Generally accounts constructed therapist bodies as not talked about in supervision.

The extract below constructs the impact of the work on the therapist's embodiment as important to be raised by the supervisor from the beginning:

Extract 21

Martha: And you were saying that you had these conversations in supervision /**Lily:** yeah/ particularly with new, umm, new colleagues or new supervisees

Lily: Yes, cos I suppose it's as, I suppose I feel that it's important that we can have an open dialogue about it, you know, because, umm, I guess that, yeah, that conversations can be had in a way where it's a, kind of, casual "oh yes. I remembered doing that in the past" but when I think that it's happening at the time, you know I think it's important for there to be open dialogue around it and /Martha: umm/and You know that if, you know, if it was a supervisee, someone I was supervising, I wouldn't want them to be concerned or worried about talking about it to me. You know, if they felt that working in this environment was triggering off issues about their own body image or around their eating, I'd, I'd want them to feel comfortable to be bringing it and talking about it. Rather than bottling it up and thinking "oh, I shouldn't be feeling this way." Umm, so, yes, so that why I'd like to, I generally like to, kind of, try to raise it as something that may happen and if it does, you know to talk about it. (**Lily:** 106-119)

Lily discursively constitutes talk of the therapist's body within supervision as both '*important*' and relevant, and her responsibility as the supervisor ('*I... try to raise it*'). This can be contrasted with other accounts that constructed reflection on therapist's body as up to the supervisee whether to raise (**Angela**: 570-571). Working in an eating dis/orders environment is constructed as potentially '*triggering*', especially when new to the field. The impact on '*body image*' and '*eating*' is constructed as to be expected, and something that she has experienced herself but no longer impacts her. It is also constructed as something that could (but should not) be '*bottled...up*', worried about, and pathologised ('*I shouldn't be feeling this way*'). The supervisor's role is constituted as one of normalising embodied experiences through bringing her own experience: '*[so] that conversations can be had in a way where it's a, kind of, casual "oh yes. I remembered doing that in the past"*'. Thus, she manages her moral location within the social interaction of supervision and this interview by taking a position that talking about the impact of the work on her own body is opening up a '*dialogue*' and thus taking care of the wellbeing of her supervisees.

3.3.4. Body talk denigrated as feminine

Accounts frequently reduced talk of embodiment to '*fat talk*', whereby the speaker complains of being 'fat' and expresses the desire to lose weight. It has been widely argued that self-degradation of the body is socially normative among women in Western culture (Britton et al. 2006). Within this discourse body talk is denigrated as superficial and vain, implicitly feminine. In the following extract Rachel constructs her overriding experience of the interview as worrying about how I might perceive her body and relationship to her body.

Extract 22

Martha: Finally, how has it felt talking to me today?

Rachel: The only thing that's been going through my head is like, that you think that I think I'm thin. (laughing) The only thing that's interesting, that's interesting in that am I giving across the impression that I think I'm like slim, so that's quite interesting

that even just talking about it makes me think I don't want her to think this or that about me. But I think this of it but, isn't that interesting?

Martha: That is very interesting, tell me a little bit about that.

Rachel: I was having the thought oh I don't want her to, I don't want Martha to think I think I'm really thin, 'cause I don't, but even just by saying, you know, I'm relatively slim, I was like- because it's not something we say very often. (**Rachel:** 593-605)

In the above extract the speaker constructs thinking of herself as thin as negative, and a self-construction she would not want me to attribute to her: "I don't want Martha to think I think I'm really thin". By describing herself matter-of-factly as '*relatively slim*', she breaks the unspoken rules of normative self-denigration between women.

Extract 23

Lily: My supervisor at the time, when I wore, on my first day there, he said to me "Don't get involved in the fashion show that goes on here" (**Lily:** 467-469)

In the above extract, staff in the eating dis/orders service are denigrated by a (male) supervisor as a engaging in a '*fashion show*'. He warns his (female) supervisee 'not to get involved'. A number of accounts referenced therapists working in eating dis/orders being often 'very slim' or 'dressed very well'. This was seen as interesting, but not elaborated on or explained. Women's attention to bodies, through dieting, clothes or otherwise, is often dismissed: 'Women are vain. Women are always so self-involved.' (Orbach, 1993, p. xxiii).

These negative constructions of body talk can be seen to reflect those of contemporary Western femininity where, linked to mind-body dualism, the embodied feminine is denigrated against controlled masculine will

(MacSween, 1993). Thus, the disparagement of embodiment extends even to the clothes women wear.

3.3.5. Therapist's body as commented on

Despite this 'taboo', participants constructed therapist's bodies as talked about and commented on by clients and colleagues.

3.3.5.1. "Don't lose too much...": The therapist's body as commented on by colleagues

Constructions of comments from colleagues centred around thinness or losing weight and sustained a multitude of meanings, including 'compliments', 'concern' and 'intrusive' (**Anna**: 133).

Extract 24

Anna: I was exercising more and I wasn't eating all the biscuits that went round and, you know, it was very definitely known and it was very definitely commented on by other therapists in the team. Umm
//**Martha**: such as/ 'Well, you've lost weight ' you know, but then it started to kick in to 'Don't lose too much' (**Anna**:104-107)

In the extract above '*weight loss*', '*exercising more*' and '*not eating all the biscuits*' are constructed as problematic and 'abnormal' within the discourses of the eating dis/orders unit. Normalising judgements through comments act to govern the therapist's body, prevent her losing '*too much*', as if therapists must stay vigilant against the seductive powers of anorexia (Moulding, 2009).

3.3.5.2. 'Why was it she needed to eat when I looked like...?': The therapist as commented on by clients

Many of the interviewees problematised the idea of a thin or '*clearly emaciated*' (**Angela**: 264) therapist in the field of eating dis/orders.

The text below constructed the thin therapist's body as impacting on the work through complicating the therapist's call for the client to gain weight:

Extract 25

Frankie: A young person once commented that I was (.) I was (.) umm (.) looked like I was thin so (.) you know (.) why why was it she needed to eat when I looked like...? And you know, things like that (.) so I guess that's where I've (.) I've been able to talk about it in supervision. You know, thinking about how it impacts on, on work with young, young people. Umm, yeah.

Martha: And how, how did you respond in that umm, that conversation with the young person? / **Frankie:** umm/ If you can remember?

Frankie: I think I just said that just, just yeah, just sort of said that the work was around helping her and, and not me. (laughs)

(**Frankie:** 125-134)

In the extract above the therapist is interpellated into the subject position of the thin therapist. From this the young person questions the therapist's credibility and moral standing in encouraging the young person to eat: "why was it she needed to eat when I looked like...?" The implication is that the thin therapist is hypocritical (**Olivia** line 407) and must restrict her eating: a double standard that she holds the young person to but not herself. Thus, the thin therapist's body is constructed as both commented on by clients and impacting on the work.

Foucault's analysis of the construction of sexuality in the eighteenth century can be seen to parallel that of the therapist's body in the context of eating dis/orders. To illustrate how the impression that 'sex was hardly spoken about' can be simultaneously accompanied by a 'constant preoccupation' with sex, Foucault draws on the example of the architectural layout of secondary schools in the eighteenth century (1976). Within the participants accounts a 'constant preoccupation' with therapist's bodies, and their relationships to their bodies can be seen: from watching and commenting on one another's bodies, to the ever-present 'high-calorie' food and incitements to eat. Thus we can

see that the therapist's body is not problematised simply through repression, but more importantly through a proliferation of discourses and discursive practices that exert power and control to render the body docile and governable.

3.4. SUBJECT POSITIONS: PERFECT PROFESSIONAL AND PATHOLOGISED OTHER

A powerful expert medical discourse could be seen in the dominant subject position was of perfect, idealised professional constituted in opposition to that of 'the eating dis/ordered patient'. I will first consider how the eating dis/ordered patient is constructed in the participants' talk, in order to better understand the position of perfect healthy professional.

3.4.1. Perfect Professional: The therapist's body as indicator of professional competence

This perfect idealised professional is '*extremely robust*' with '*no mental health problems of their own*'. In the extract below Olivia troubles the concept of the perfectly robust professional with perfect body image:

Extract 26

Olivia: I suppose that there is this assumption that, as clinicians, we are these extremely robust sort of professionals. I guess that, you know, (.) working with eating disorders everyone has a body, everyone has an experience of their own body and I don't really believe or I don't really buy the fact that no one has ever had, you know, concerns or issues with their own body image.
/M: Mm hmm/ but I think there is this assumption that it is either, you know, we have absolutely perfect body images or have never disliked what we see in the mirror and I just don't think

that's really accurate or or genuine or fair to our clients to sort of portray that image really /M: mm/ either. (**Olivia:** 40-48)

Here, this extract references the technologies of power that govern therapists' conduct at a distance and the pressures to fit within the subject position of the professionalised body. This extract displays a 'truth game', setting up this perfect professional position as both unrealistic and unethical, and thus placing herself outside this discourse with a greater claim for both honesty and ethical practice. This construction is supported by other accounts in the transcripts, for example clinicians being expected to have 'beautiful mental health' (**Luke:** 572-575).

The discourse of self-improvement and professional self-care towards perfection constructs perfection as within our grasp, something that should be striven for. This discourse of self-improvement and self-care can be seen more widely in the context of late capitalism and the individualised subject, where perfection and happiness is achievable if we work hard enough. This discourse interpellates the therapist subject as lacking or 'incompetent' if perfect body weight and shape, and contentment with that body, perfect eating and on a wider scale perfect mental health and perfect professional are not achieved. That Olivia reflects on and rejects this discourse of achievable perfection allows her position to non-perfection alternatively as more 'accurate', 'genuine' and 'fair'. The implication is that she is also fallible and human like her clients, which acts to address the power differential.

The position of perfect healthy professional in terms of body, body image and mental health has strong parallels with Surtee's (2009) analysis of the Professional One / Pathologised Other in an inpatient eating dis/order setting. This dichotomy reflects the concept of the unhealthy anorexic or eating dis/ordered body or the healthy, non-eating dis/ordered body (Gremillion, 1992, 2003; Moulding 2003, 2006).

The extract below draws on societal stigma towards mental health to account for pressure to have perfect mental health.

Extract 27

Luke: It's part of a wider stigma about mental health, that, of course, it's, it's crazy to think that we don't have neuroses and insecurities and weak spots but, yeah, as a mental health professional or a psychologist, there is something of a pressure to umm, have beautiful mental health (**Luke:** 572-575).

Again this extract troubles the idea of perfect mental health as unachievable, even using the language of the stigmatising mental health discourse: making the 'truth claim' that it would be 'crazy' to expect mental health professionals to not have their own insecurities. This leads into the discourse widely referenced in the texts and the wider literature on body image: that of 'normative discontent'.

3.4.2. Therapist's body as subject to 'normative discontent'

Normative discontent is a term coined to describe the prevalence of body dissatisfaction among women in the Western world (Polivy & Herman, 1987). It is framed as pervasive body image dissatisfaction, associated with eating problems, which reduces the quality of women's lives sufficiently to warrant prevention programmes (e.g. Body Confidence Progress report, 2015). It is linked to the relentless pursuit of thinness for girls and women in western societies, and the thin female body ideal.

The discourse of 'normative discontent' is deployed within CBT to normalise women's dissatisfaction with their body. Therapists, as women, are constructed as subject to the same discourses as those impacting their clients. Therapists are framed as subject to normative discontent in the following extract.

Extract 28

Rachel: This might be my interpretation of it, it might be my position within that but (intake of breath) I would feel very uncomfortable

ever talking about, well not ever but, talking much about having gained weight or um something not fitting right or, I don't think I would feel comfortable talking to my colleagues about that because I think it might be, um, I think it might be frowned upon

Martha: And what is it do you think that means it's frowned upon

Rachel: I always talk to my patients about normative discontent in people's body image, so on one hand I teach you know I talk to my patients about that being quite a normal thing but I think it would feel, I would be concerned that people might think I've got a problem or that I'm, you know, you know, if you've got, if you've got any issues with your body image then you are, you are maybe not in a, in in a position to be that objective voice for your patient. (**Rachel:** 60-71)

In this transcript the discourses of normative discontent comes into conflict with the subject position of perfect healthy professional. The therapist must be neutral and detached with no 'normative discontent' of their own. The therapist is positioned as needing to be 'objective', drawing on the scientist-practitioner model that currently dominates clinical psychology. The authority to speak as the objective, neutral and homogenised idealised psychologist requires distancing yourself from personal identities and experiences of embodied distress (Callaghan, 2006).

If the therapist were subject to supposedly normative discontent they become too like the pathologised Other. While claiming to espouse that body discontent is 'normative', at the same time talking to colleagues about discontent would be uncomfortable and 'frowned upon'. Body dissatisfaction is framed as both normal and at the same time pathologised within the expert clinician vs. pathologised patient dichotomy. Within this dichotomy, anything less than complete body satisfaction and acceptance is pathologised: "if you've got any issues with your body image then you are, you are maybe not in a, in in a position to be that objective voice for your patient".

3.4.3. Pathologised Other: the therapist's body as indicator of pathology

3.4.3.1. Those with previous experience being attracted to eating dis/order work

There are multiple allusions in the accounts to the belief that those with a previous history of an eating dis/order are attracted to the profession and this speciality. This echoes the literature on the 'wounded healer' (Jung, 1951) that holds that the therapist chooses to work with clients primarily because they have also suffered the same 'wound' (Murphy & Haglin, 1995). This narrative seems to hold particularly true for eating dis/orders. This discourse, combined with that of personal history as weakness and professional, warrants surveillance of eating dis/orders therapists in order to monitor them for signs of an eating dis/order. The professional with personal experience of distress is placed outside expert discourses of professionalism as 'Other' (De Beauvoir, 1949).

3.4.4. The biomedical discourse: Constructing professional one and pathologised Other

Foucault's theory of governmentality and regulation of the body (1967, 1970, 1972, 1973, 1979) explains the progressive medicalisation and objectification of bodies since the seventeenth century and provides a backdrop for understanding the normalisation of contemporary bodily self-surveillance practices. His emphasis on the centrality of language in the exercise of power (Foucault, 1977, 1980) furnishes researchers in the field with an invaluable framework for critiquing the medical and psychiatric gaze, in particular the psychiatric diagnostic categories and therapeutic modes imposed on those who self-starve (Eckermann, 1997, 2009; Turner, 1992).

The current prevailing model within clinical psychology in the UK is that of the psychologist as scientist-practitioner (Division of Clinical Psychology, 2010) which allows for the construction of psychologist as expert, objective scientist. This contributes to the construction of the personal and professional as

separate, and the personal as outside of the sphere of professional discussion.

3.4.5. Technologies of self: Producing healthy professional

The discourse of professionalism operates differently in the field of eating dis/orders, where professionalism is uniquely embodied. Health is demonstrated in opposition to a diagnosis of eating dis/order, and thus professionalism is visible. This visibility facilitates government of the therapists' body through watching. The body is an indicator of professional ability, and so various technologies of power act to govern therapists' conduct in relation to their body.

The constructions of Professionalised One / Pathologised Other have implications for the ways-of-being available in the eating dis/orders unit. Within the eating dis/order unit good professional mental health is framed in terms of body, bodily practices and relationship to body. Therefore therapists are 'doing' perfect robust professional by performing (Butler, 2011) a repertoire of bodily practices or 'technologies of self' (Foucault, 1986). The therapist's body becomes an indicator of professional ability.

3.4.5.1. Producing professional: Silencing

Health clinicians are expected to conform to layers of governance at national and local levels, with managerial and professional bodies disciplining their own individual bodies as part of the normalising process of "professionalisation" (Fournier, 1999). Below, we can see an account of a professional 'self-disciplining' herself through silencing.

Extract 29

Kontiki: I went in after Christmas, and I went into the office to go and make a cup of tea //M:mm/ and umm people were, people were saying things like "Oh, you are looking really well" and then you say, (laugh) so like, my *normal* response to that might be "Oh,

does it look as if I've eaten too many mince pies" or something like that cos I'd been away on holiday, but I felt conscious of *not* saying that because most of the people in the room were eating disorders clinicians (...) It was interesting that I stopped myself from a joke that I would normally say (...) I don't know if it's specific to my team //M:mm/ or something about *me* or if this happens in lots of teams and people then become so conscious about not wanting to talk about their bodies that they don't say anything at all. (**Kontiki**: 47-74)

In the above extract we can see that what is considered 'normal' joking becomes heavily charged in the light of the individualisation and pathologisation of anything less than perfect body image and absolute acceptance. Many participants wondered whether this feeling of body talk being silenced was their own individual experience: 'I don't know if it's specific to my team or something about *me*'. This demonstrates how silencing and not talking individualises, pathologises and obscures collective experience.

3.4.5.2. Producing professional: Eating and food

The other way that the participants' demonstrate their professionalism is through overt eating. This is one of the technologies of power and self by which the therapist's body is regulated. In the extract below Luke performs 'healthy professional' through eating.

Extract 30

Luke: I think there is a little bit of checking out of each other of those things, /M: umm/ Umm, and so yeah it was a bit of a relief when I'd, kind of, had a big plate of chips in front of my colleagues.
(laughs) (**Luke**: 119-121)

In the extract above the role of 'healthy professional' is performed through eating '*a big plate of chips in front of my colleagues*'. The construction of the prevalence of 'high calorie' food in eating dis/order services can be seen in

other accounts (e.g. **Rachel** 114-116, **Olivia**: 62-68). It seems that within the very particular biomedical, dietetic discourses of the eating dis/orders unit what is constituted as a good diet is very different to society at large, where a plate of chips would generally be seen as unhealthy.

3.4.5.3. Producing professional: 'I don't have an eating dis/order'

Extract 31

Angela: if a patient is able to talk about it and is worried by seeing their clinician losing weight then I'd have a solution to that, which is that I haven't got an eating disorder (**Angela**: 317-326)

In the above extract the speaker neutralises a hypothesised potential pathologisation of her body. In the extract she manages the moral dilemma of weight loss as potentially impacting on clients by taking up the subject position of '*I haven't got an eating disorder*'. Taking up the position of healthy professional acts to silence body talk, talk is no longer warranted. However, this 'solution' acts to pathologise those clinicians who have lived personal experience.

3.4.6. Professionals with lived experience

3.4.6.1. Implications for subjectivity: Silence, stigma and shame

The below extract constructs personal experience of eating and body distress as stigmatised.

Extract 32

Olivia: I would have all of these negative thoughts about people thinking I couldn't do my job properly or (.) /M: mm/ people thinking that um (sigh) I was doing this for selfish reasons or people thinking that I wasn't sort of (.) y'know all these really catastrophic thoughts of being y'know kicked [*out of the job*] and never employed and things and (.) these things all didn't

transpire and I kind of know in my logical mind that it wouldn't have been the case /M: mm/ but I still felt a lot of stigma about the idea of being open about my own mental health difficulties and my own pr- problems with body image (**Olivia**: line 265-274)

Here '*mental health issues*' and '*problems with body image*' are constructed as stigmatised. The speaker names fears of the implication of speaking openly '*other people thinking I couldn't do my job properly*' or that they would be '*never employed*'. This is similar to other accounts of fear of disclosure in these interviews (e.g. **Robin**).

The extract below constructs talking about disclosure of personal experience of an eating dis/order as upsetting:

Extract 33

Robin: I found [them] a bit cold but then I think that was just them being very boundaried and so I left (...) feeling quite vulnerable and so I spoke to my therapist, well so I left (...) I felt [inaud], I was quite upset (**Robin**: 549-551)

Shame can be seen as a regulatory practice in the reproduction of power and privilege. A number of accounts constructed the therapist's embodiment as shameful and difficult in the context of eating dis/orders.

Extract 34

Martha: I'm wondering what your thoughts are on the impact of not talking about things are on people

Olivia: Umm well I suppose from my quite biased perspective it's just made me feel like I've bottled up this massive secret for ages that I can't really talk about that I sort of wish I could be a bit more open about I wish it would be a bit more accepted I don't know that it wouldn't be accepted as again I said I'm only at the very early stages of my career and about thinking of this um but yeah I suppose it would have made me feel a bit more like I

wasn't a fraud or I wasn't y'know /M: mm/ y'know masquerading as a healthy person who actually had a history of an eating disorder (**Olivia**: 855-864)

In the above extract the impact of silencing bodies and body talk is to construct personal experience as a '*massive secret*'. The professional one / pathologised other dichotomy can be seen in the idea that you cannot be both '*healthy*' and have '*a history of an eating disorder*'. To claim to be healthy with lived experience is constructed as feeling a '*fraud*' or '*masquerading as a healthy person*'. Not talking is constructed as a burden, which individualises and pathologises the speaker's distress, obscuring collective experience and strengths there might be with other experts by both professional and lived experience.

3.4.6.2. 'That's why she's so great': Personal experience as a strength

Despite dominant biomedical discourses acting to pathologise lived experience of an eating dis/order, there was evidence of resistance and counter-discourses that offered alternative, empowering subject positions such as expert-by-experience. Personal experience of having lived with an eating dis/order was constructed as a strength in a number of the extracts. The extract below constructs personal experience as increasing empathy and understanding.

Extract 35

Olivia: If someone like [*a famous eating dis/orders clinician*] got up and admitted after like a lifetime of service by the way I had binge eating disorder or bulimia or whatever for for like however long I think (.) I think it would be more like *that's why she's so great* /M: yeah/ y'know (.) I dunno (.)

Martha: (inaud) (.) So then at at that point it would be evidence a kind of strength

Olivia: Yeah maybe this is just in my mind because again it wasn't I got the impression I got from my supervisor when I talked to her /M:

mm/ it wasn't I didn't get the impression that my experience would be a strength /M: right yeah/ whereas I've always thought it was my secret strength (Olivia: 519-534)

In the above extract personal experience of living with an eating dis/order is constructed as a 'strength'. In an example of co-construction, I introduce the word '*strength*', which is then taken up and elaborated on to become '*secret strength*'. At the beginning of the extract the disclosure of a famous eating dis/orders clinician '*by the way I had binge eating disorder or bulimia*' would be seen as positive, but only once their reputation was assured '*after like a lifetime of service*'. 'I think it would be more like *that's why she's so great*'. The speaker contrasts this with the response from her supervisor when she talked about her personal history, 'I didn't get the impression that my experience would be a strength'. Here, the power differential and subject position of being early on in her career make the speaker vulnerable within the dominant pathologising discourses and stigma surrounding lived experience. However, she does not take up this position of implied weakness. Instead, we construct her personal lived experience as helping the work, her '*secret strength*'.

This construction of personal experience as strength calls to mind the term 'expert-by-experience', championed by the service user involvement and survivor movements (Noorani, 2013). From here the empowering subject position of expert-by-experience, with related experiential knowledge and authority, can be claimed.

3.5. SUMMARY

This thesis aimed to explore how therapists construct their own bodies when working in the context of specialist eating dis/order services using FDA. In this chapter I have explored how therapists working in the field of eating dis/orders construct their own body. I have argued that the therapist's body is problematised in a number of inter-connected ways: (1) as both impacting on and impacted by the work, (2) as both talked about and not talked about, (3)

as visible and watched, and (4) as subject positions of healthy professional and pathologised Other.

The next chapter will evaluate these findings and consider implications for clinical psychology research and practice.

CHAPTER 4 - SUMMARY, EVALUATION AND IMPLICATIONS

This chapter summarises and discusses the analysis findings. To further evaluate the quality of this research established criteria will be used including coherence, sensitivity to context, rigour, transparency and reflexivity (Yardley, 2008). Methodological issues are also considered. Finally, attention is given to implications for clinical practice and recommendations for future research.

4.1. Research questions and analysis summary

In order to answer how therapists working in eating dis/orders talk about their own bodies, analysis was guided by the following research sub-questions:

- 1) How is the discursive object of the therapist's body constituted and made problematic? What discourses are available?
- 2) How is therapists' conduct governed at a distance (technologies of power) and by therapists themselves (technologies of self)?
- 3) What embodied subject positions and practices are made possible within these discourses?
- 4) How do clinicians take up, negotiate and contest these processes of subjectification?

The therapist's body was constituted and made problematic in multiple ways: firstly, in relation to the work of eating dis/orders; secondly, as visible and watched, relating to technologies of power and self; thirdly, as paradoxically both silenced and talked about; and finally within subject positions of 'perfect healthy professional' and 'pathologised (un)professional Other' where the body is an indicator of professional ability or pathology.

4.1.1. The therapist's body as both impacted by and impacting on the work

The talk rendered the therapist's body problematic through relevance to the work: as impacting on, and impacted by, clinical practice in eating dis/orders. The work was constituted as bombardment by multiple discourses about bodies, which differentially constituted the therapist's body with shifting implications for subjectivity.

Within a individualising biomedical discourse, broader sociocultural values such as idealisation of thinness, denigration of fat, and preoccupation with 'healthy' (restricted) eating, become detached from their wider sociocultural context, and internalised within service users. These body discourses attributed to clients constitute the therapist's subjectivity, becoming '*part of your own thinking*', with negative implications for therapist's relationship to their body and body practices. This can be seen as reflecting how language constructs experience. However, the dualistic idealisation of thinness and denigration of fat can be seen as a 'crystallisation of culture'. The preoccupation with 'healthism' and denigration of 'fat' are supposedly pathological in those given a diagnosis of an eating dis/order, but are in fact indistinguishable from dominant societal norms (Malson et al., 2008).

Biomedical and dietetic discourses particular to the eating dis/orders unit construct women's bodily and eating distress as pathological in relation to a very different norm to that of societal restriction. Therapists discipline the bodies of their clients through a number of technologies of power: normalising judgements, observations, and the combination of the two in examination (Foucault, 1977). Through applying these as technologies of self, the therapists become self-disciplining subjects 'practicing what you preach'. This can be seen in daily weigh-ins, and rules about eating three meals and two snacks a day. The functioning of modern power can be seen clearly within the eating dis/orders unit, acting not just on service users but on therapists to render their bodies docile (Foucault, 1979).

The implications for subjectivity on the therapist's body, through internalisation of eating dis/order (societal) values and new professional norms of what constitutes 'normal', were constructed as initially strong when the therapist began working in the field. However they were constituted as less relevant, less talked about, with increasing experience. It was unclear as to whether this was facilitated by processes of 'normalisation', forgetting, gaining experience, age, or another process.

Alternative embodied, discourses that positively constituted the impact of the work on the therapist included psychodynamic discourses, whereby impact of the work on the therapist's embodiment becomes meaningful through countertransference. Furthermore, feminist discourses constituted experience of eating dis/orders, either through the work or personal recovery, as having a positive impact on therapist's embodiment through facilitating a critical stance to dominant discourses, for example being 'anti-diet'. Noted above, constructions of the thin ideal as 'becoming part of your own thinking' call to mind societal discourses as infectious. When contextualised, personal and professional experience of the palpable 'self-destruction' of eating dis/orders (Malson, 1998), immunises the therapist's body against the siren call of feminine ideals of beauty.

Problematisations of the therapist's body as both impacting on and impacted by the work warrant a number of disciplinary practices, which I consider below.

4.1.2. The therapist's body as visible and watched

Therapists were constructed as subject to multiple 'normalising gazes' (Eckermann, 2009, p. 11) from clients, colleagues, themselves and society. Biomedical discourses of eating dis/orders as 'objective' and observable act to produce the therapist's body as a visible signifier of health, professionalism and pathology. The therapist's body becomes particularly problematic based on thinness, eating (or not), and visible change such as weight loss. Technologies of power were evident in the panopticism (Foucault, 1977) by

which the therapist's body came under surveillance from clients and colleagues who 'raise an eyebrow' if a therapist refuses cake. These disciplinary practices act to govern therapists' conduct. Technologies of self could also be seen in constructions of therapist self-surveillance and self-objectification, such as through preoccupation with appearance and 'healthy' BMI.

However, previous research has highlighted that such a simplistic reduction of eating and body distress to that which is visible and observable may paradoxically pathologise those who do not engage in technologies of self to reduce their weight, while invisible technologies of self such as compulsive eating or 'bulimia' remain unproblematic (Surtees, 2009). The paradoxical meanings of the thin therapist's body seen in the accounts parallel those seen in other FDA analyses of the thin/anorexic woman (e.g. MacSween, 1993; Malson, 1998).

Similarly, constructions of the therapist's body as body image, drawing on discourses of mind-body dualism, render the body as static and reduce it to appearance (Probyn, 2009). In terms of subjectivity, body image discourses have been criticised for 'othering' the body so it is regarded from some external viewpoint rather than inhabited. This acts to obscure physicality and the full range of embodied experiences.

This reductionist, decontextualized construction of the therapist's body has implications for clinical practice. It is increasingly being argued that in order to alleviate eating and body distress, the body must be sensed, experienced and lived rather than viewed or judged (Cook-Cottone, 2015), though 'body image' is generally proposed to be the solution. If the dominant discourses available within eating dis/order services are disembodied, it would be difficult for therapists to nurture client discourses that provide embodied ways-of-being. Thus, I propose embodiment would be a more useful concept.

4.1.3. Talking: The therapist's body as both talked about and not talked about

The therapist's body was paradoxically constructed as both talked about and silenced. This parallels Foucault's (1979) repressive hypothesis of sex, whereby received wisdom of the 'imposition of silence', is in fact accompanied by a proliferation of discourses. Therapist bodies are not talked about in official spaces such as supervision, but over lunch or in the corridor. This new regime of discourses obtain different results: not thoughtful embodied reflection, but discipline of the body so that the therapist conforms to biomedical norms of 'health'.

Multiple constructions of the therapist's body rendered it difficult to talk about in formal reflective spaces, such as supervision: the therapist's body as private; bodies as impolite and taboo, like sex; embodied reflection as a luxury within current political-economic contexts; and body talk denigrated as feminine and vain. Many of these constructions rely on discourses of mind-body dualism, where the therapist's subjectivity is constituted as a disembodied mind/self, dissociated from the body which is produced as alien, uncontrolled, sexual, feminine and dangerous (Malson, 1998; Ussher, 1992a). These Cartesian discourses have been implicated as producing the body distress and control of eating dis/orders and women more generally (Bordo, 1990, 1993b; Malson, 1998). Discourses of mind-body dualism and the construction of the rational/disembodied professional in relation to the bodily/pathologised Other act to silence talk of the therapist's body.

Accounts differentially constructed the responsibility of talking about the body as the client, the supervisee, or the therapist. Talk was diverted back onto the client if they introduced the therapist's body: the therapy is about the pathologised Other, not the professional One. Furthermore, junior clinicians constructed it as the supervisor's responsibility to make an open safe space for body talk, while other accounts emphasised the supervisee's responsibility. Given power and positioning act to silence body talk, it seems pertinent that those in the relatively more powerful position should introduce and depathologise talk of the body.

4.1.4. Subject positions: perfect healthy professional and pathologised Other

This analysis elucidated constructions of two dominant, dualistic subject positions within a biomedical discourse by which participants were classified as perfect professional or pathologised Other. The construction of the Other was so all encompassing in pathologisation that it seemed to have its own gravitational pull, engulfing everything so that all but a very narrow range of bodies and practices come to be subject to disciplinary technologies of power and self.

Thus, previously unproblematic aspects of the body and body practices become a problem: turning down a biscuit, 'healthy weight loss', anything but 'perfect body image', or wanting to reflect on your own body in supervision. What was left is an impossibly narrow, one-dimensional 'perfect healthy professional' who feels nothing but positive in their body, does not talk about their body, is neither 'thin' or 'fat', fits within the 'normal' BMI, eats three meals and two snacks a day, eats big plates of chips, always says yes to cake, and should not have a personal history of an eating dis/order.

Participants shifted through multiple, often conflicting subject positions in relation to their body: from struggling to take up this idealised subject position of perfect healthy professional to actively resisted it as a 'subject imposition' (Malson et al., 2008), and finding themselves interpellated as 'pathologised Other'. Furthermore, participants positioned their colleagues as pathologised Other: as 'visibly underweight', 'anorexic doctor' or 'functioning anorexic'. Thus the individual embodied therapist 'emerges through the processes of social interaction (...) as one who is constituted and re-constituted through the various discursive practices in which they participate.' (Davies & Harre, 1999, p. 35).

This all encompassing pathologisation of the therapist's body mirrors the construction of 'the eating dis/ordered patient' as 'entirely pathologised' in another FDA analysis of client accounts of treatment experiences (Malson,

Finn, Treasure, Clarke, & Anderson, 2004). Malson et al. (2004) expresses concern that biomedical discourses reduce individual worth to a narrow set of criteria of food, eating and weight, re-enacting rather than challenging the unhelpful values that contribute to eating dis/orders.

My analysis shows the importance of challenging a restricted focus on the body as 'pathology', reduced it to increasingly all-encompassing visible symptoms. Instead, I argue we should be elaborating non-pathologising constructions of embodiment, set within wider sociocultural context. If there is not a credible subject position for clinicians to take up from their relative position of power, other than 'perfection', the possibility of recovery for service users seems to be precluded. Again, as so many feminist scholars have said previously, the discourses of the eating dis/orders unit seem to reproduce the very discursive conditions thought to produce eating dis/orders in the first place (Gremillion, 2002; Malson et al., 2004).

In summary, therapists in eating dis/orders constructed their own body in multiple complex and contradictory ways. Firstly in relation to practice, as both 'impacting on' and 'impacted by' the work. Secondly, as 'visible' and 'watched' for signs of pathology, demonstrating technologies of power and self through observation and examination. Thirdly, as paradoxically both silenced and talked about, with the normalising judgements of both clients and colleagues demonstrating more technologies of power. Fourthly, constructions of the therapist's body interpellated them into subject positions of perfect professional One and pathologised (un)professional Other, demonstrating the implications for processes of subjectification.

4.2. Quality evaluation

This section draws upon Yardley's (2008) evaluative criteria to judge the quality and validity of this research.

4.2.1. Sensitivity to context

Yardley (2000, 2008) argues for the importance of sensitivity to multiple contexts: previous literature, social context, the relationship between interviewer and interviewee, and power. The research and literature context is addressed in chapter one, and attention to positioning and power can be seen in reflexivity (sections 2.10 and 4.4).

Generation of new meaning is a characteristic of good qualitative research Yardley (2000, 2008). I have endeavoured to present new understandings of the way the therapist's body is constructed within eating dis/order services by considering wider context, discourse and power. Though problematisations could already be seen in the literature, for example the therapist's body as 'taboo', the majority of the features of the analysis were not stipulated in advance. For example, I had not anticipated the dominance of mind-body dualism, perhaps because it is so taken for granted it becomes invisible. It was only through analysis of the implications of mind-body dualism for power and subjectivity that I came to the conviction that embodiment is vital within eating dis/orders theory, research and practice.

4.2.2. Commitment and rigour

I believe the size and composition of the sample is appropriate to address the research question (see 2.5.1). Recruitment represented breadth in terms of both level of experience, and service contexts of adult and CAHMS. Nationally, most therapists work in outpatient settings and CBT is the dominant model, which was reflected in the participant group. Participants primarily trained in psychodynamic modalities were not represented.

To maximise skill in analysis I selected a supervisor with experience in both embodiment and FDA research; engaged in peer supervision with trainees using similar methodologies; and read literature of embodied FDA research within eating dis/orders and elsewhere.

Once I had identified constructions and discourses I systematically sought out disconfirmatory cases in order to mitigate the influence of my own assumptions and interests (Creswell, 2012). In fact this augmented the richness and complexity of my analysis by drawing out conflict and contradiction, or example the paradox of the therapist's body as both talked about and not talked about.

I believe my analysis was deepened by prolonged engagement with the topic, immersion in the data and personal experience of working in eating dis/order contexts. A danger of my 'insider' position was the risk of inadvertently foregrounding my own personal experiences, at the expense of participants' accounts. As a measure of analytic credibility I will seek participant feedback (Mays & Pope, 1995; Yardley, 2008). Nearly all participants took up my offer of sending the finalised thesis, and I have offered to present findings to the teams from which I recruited and also where I have worked. I will also offer participants a copy of their own transcripts in order to aid their own reflection. This will enable participants and other therapists who work in eating dis/order services to challenge and develop my interpretations.

4.2.3. Coherence and transparency

I have repeatedly returned to the research questions throughout the process of designing, conducting, analysing and writing up to anchor this research in its aim and ensure coherence (Yardley, 2008).

Transparency can be seen in both acknowledging and analysing how I as researcher may have influenced the findings through reflexivity (4.4. below), and in providing sufficient detail of the methodology (chapter 2). As recommended by Yardley (2008) a paper audit trail is available on request including the hand-coded paper transcripts, electronically coded NVivo transcripts, and diagrams, questions and notes guiding the reasoning behind the analytic decisions².

² See appendices 7-9 for examples of the paper trail

4.3. Limitations

4.3.1. Interviews

I have outlined my reasons for using interview data based on the ethical and practical challenges of other methods (see 2.4.1). A limitation of this research is that the talk was not naturally occurring and therefore was more open to my influence as researcher (Potter & Hepburn, 2005). In order to address this I have endeavoured to provide transparency as to my position through reflexivity and contributions, for example including my questions as interviewer within extracts.

Analysis of the therapist's body in relation to talking could be criticised for being epistemologically awkward, as it involves accounts of accounts, 'talking about what has been talked about' in relation to the therapist's body (Malson et al., 2004). However, Malson et al. (2004) argue that intertextuality is inevitable and can be seen as a 'folding in' of other discursive resources. Furthermore, this research is concerned with how therapists discursively constitute their body, and does not seek to make claims about the relationship between participants accounts and the 'reality' of what is said in relation to their bodies, for example in supervision. Further research using a different methodological approach would be needed to address such questions.

4.3.2. Transcription

Hepburn (2006) has observed that transcription is inadequate to capture practices such as crying. I was aware during the process of committing interviews first to audio tapes, and then to written words something of the embodied nature of the interactions was lost: the body-to-body interactions were stripped of tone of voice and bodily comfort, moments of aliveness and moments where the interview seemed stuck. Analysing extracts, there were

points where my memory of an interaction conveyed a very different meaning to the words I now had written in front of me.

4.3.3. Theorising embodiment on the basis of discourse

There are numerous challenges of using talk to research embodiment (Brown, Cromby, Harper, Johnson, & Reavey, 2011). While conducting interviews it became clear that language was insufficient to fully capture the body. Felt, sensed embodiment seemed elusive and '*hard... to articulate*' (Olivia: 252). Interestingly, talk of embodiment became more immediate and alive when I asked, initially off the cuff and then deliberately at the end of the interview, 'How does it *feel* having these conversations about bodies?' (e.g. Olivia: 714). These in-the-moment descriptions produced far more vivid accounts than recollections of experiences of their body. Embodiment is not well served by memory, especially as physicality is not commonly attended to after the fact (Brown et al., 2011). Future research could focus on capturing embodiment in the moment.

Furthermore, researching the body through discourse could be argued to reinforcing mind-body dualism at the same time as attempting to deconstruct it. Attending to the body *qua* body (Orbach, 2004) remains a methodological challenge (Brown et al., 2011). However, I do not feel we should be idealogues about the shortcomings of current methods in addressing embodiment. Rather we should get 'down and dirty with the body on the level of its practices' (Bordo, 1998, p. 91) to ensure these challenges do not act to reinforce the exclusion of the body from theory, research and practice.

4.3.4. Generalisability

Dominant quantitative standards of generalisability are incompatible with my epistemology and methodology. However, the analysis findings are "vertically generalisable" in that they link to previous work and broader sociocultural discourses and institutional practices (Johnson, 1997).

4.4. Reflexivity

4.4.1. Epistemological reflexivity

It is traditional in social constructionist research to acknowledge that the research is a construction. I would like to go further and assert that this research can be seen as a disciplinary practice in itself. This thesis demonstrates technologies of both power through observation in interviews, examination in analysis, and normalising judgements through my recommendations. Indeed, Foucault has been criticised for leaving little room for emancipation. However, it has been argued that Foucault's later work allows for resistance, with the subject as 'social agent capable of innovations and produced out of the clash between contradictory subject positions and practices' (Weedon, 1987, p. 125). Thus, out of the 'clash' of this thesis with dominant discourses of eating dis/order services I hope to produce potential for innovation and agency.

4.4.2. Personal reflexivity

I have been guided by a number of ethical practices advocated by feminist poststructuralist researchers (Rice, 2009). Three important interrelated issues have been identified when conducting qualitative research: ethics, power and difference (Wolf, 1993). I have previously come to feel uncomfortable with the ethics, power differential and echoes of colonisation when conducting research solely focused on the 'other'. For this thesis I turn the research gaze on those who are similar to me in that they work in the field of eating dis/orders. I hope that taking a position alongside my participants acts to address the inherent power differential and process of 'othering'.

I have exercised caution in assuming insider knowledges and taken care to foreground the accounts of my participants. Researcher responsibility involves immersing oneself in experiences, worldviews and challenges of communities under investigation (Merrick, 1999), which is an advantage of the insider-

researcher position. However, insider-researcher position may be more problematic given the results of the analysis that suggest peers are constructed as observing and judgemental, which may constrained talk.

I recognise the ways in which this research conceived through the intersection of my identities and personal experiences as a therapist who worked in eating dis/orders, a feminist, an academic and a 'thin woman', and that this will have shaped the data collection and analysis. This research is of course situated within and shaped by the relational dynamics of the interview encounters (Broom, Hand, & Tovey, 2009). I acknowledge my personal and political investments in this research. I feel more open conversations about clinician embodiment would be welcome in the eating dis/orders unit. However, reflexivity around the contribution of my own subjectivity should not eclipse the importance of my participants' accounts.

Just as in psychology at large, both researcher and participant embodiment are generally ignored in considerations of reflexivity. Rice (2009) argues that where appearance and embodied difference are of crucial social relevance, as in this research, it is important that they are not then overlooked or assimilated into more common social identities such as gender, race or class. In terms of my own embodiment I am described as, and would describe myself as, a thin woman. Thinness seemed to be particularly problematised in the accounts. This may be due to the presence of my own thin body as an interviewer. Though equally it could be postulated that this could censor negative or pathologising constructions of thinness, out of consideration for my feelings.

To paraphrase Probyn (2009), there is nothing like being immersed in literature around eating dis/orders to make you feel somewhat strange in your body. I have noticed that through writing this thesis I have been uncomfortably embodied.

4.4.3. Reflections on Foucault

Struggling to get to grips with Foucault when embarking on this research, it was a relief when I read Bordo's (1993a) account of her initial impressions of Foucault and post-structuralism:

'The language was too self-conscious, too eroticised for my tastes; I felt instinctively that I could never wear such *haute couture* with comfort and conviction.' (Bordo, 1993a, p. 179)

Learning to wear the '*haute couture*' of FDA with comfort and conviction has been a difficult process, and one I am unsure I have yet successfully achieved. However, the process of this research has deepened my appreciation of post-structuralist approaches' ability to call into question taken-for-granted knowledge, by radically shifting my understanding of my own body from dominant discourses of body image to that of embodiment.

4.5. Importance of this research

This thesis makes a novel contribution to the literature on the therapist's body in eating dis/orders in two major ways. Firstly, no previous published research has addressed the therapist's body from the therapist's perspective in the UK. Secondly, it is the first study to utilise FDA in addressing therapist's accounts of their own bodies. FDA allows attention to the complexities, silences and paradoxes of talk (Arribas-Ayllon & Walkerdine, 2008). Thus, the present research study has sought to illustrate *how* the discourses of the eating dis/orders unit act to make the therapist's body particularly problematic in this context. Commitment to retaining complexity and detailing of the functions of power make this study a unique contribution to the literature on the therapist's body in eating dis/orders.

4.6. Possibilities for further research

Exciting methods of researching embodiment are opening up (Brown et al., 2011). There are numerous possibilities for future research into the therapist's body in the field of eating dis/orders.

From the present study it is clear that the discursive repertoire therapists have to talk about their body is limited. Participants found it difficult to talk about their body in a one-hour one-off interview, given they were unused to reflecting on their embodiment and there was limited time to build rapport. Though this was not possible within the time restraints of the present study, in future data could be collected over repeat or 'serial' interviews. Serial interviews allow for a greater quality of relationship to develop over time, providing opportunities to understand interviewees multiple shifting identities and realities, as well as seek clarification and layer meaning (Vincent, 2013). Serial interviews have been highlighted as particularly appropriate for sensitive issues where you want to access private accounts, an advantage for the taboo and very personal issue of therapist's body (Murray, Kendall, Carduff, Worth, Harris, Lloyd, Cavers, Grant & Sheikh, 2009).

In future research, creative methods could be used to spark new kinds of conversations about embodiment and so elaborate on alternative discourses of the therapist's body. Diaries or visual methods such as photo-elicitation (Lapenta, 2011) could be useful to elicit 'deep and interesting talk' on a topic which is otherwise difficult to explore (Harper, 2002, p.23). There are various approaches to photo-elicitation, but broadly either the interviewer or interviewee would select photographs with meaningful content on the topic of the therapist's body, which can then be discussed and interpreted together in the interview to generate rich data. In the present study one participant reflected that the interview style of questioning around her body felt 'like some kind of evaluation' (**Anna**: 423). An advantage of photo-elicitation is its collaborative nature, facilitation of rapport, and ability to avert the artificial and potentially awkward interviewer-interviewee question-and-answer power

dynamics, as interviewers 'are asking questions of the photographs, and the informants become our assistants in discovering the answers in the realities of the photographs' (Collier & Collier, 1986 p.105). Thus, photo-elicitation's non-verbal nature and ability to foster rapport, collaboration, rich talk, memories and specific examples are advantages that address many of the challenges of collecting data on therapist embodiment in eating dis/order contexts.

Another participatory method that could generate rich and interesting data on therapist embodiment is Memory Work (Stephenson & Kippax, 2008).

Memory work is a social constructionist, feminist method where research is collectively conducted and analysed by a group of researcher-participants. It uses groups and repeated meetings and foregrounds the complexity of embodiment, feelings and sensations. Memory Work was not suitable for an individual doctoral thesis as analysis is conducted collectively by the group, and having a clear leader precludes equal and active participation (Stephenson & Kippax, 2008). Memory Work is based on feminist principles that espouse research as social action and has potential to produce change through the method itself. My recruitment resulted in much interest from clinicians expressing a desire to take part in research about their own bodies, suggesting there is an appetite for reflecting on embodiment in eating dis/order contexts. 'Trigger' themes to generate embodied memories could be clinical, for example 'therapy' or 'supervision', or non-clinical for example 'eating' or even 'menopause'. I believe that such action research could explore alternative embodied ways of talking, and, more importantly, ways of being that therapists could carry into their practice.

4.7. Implications

I have sought to contribute to the growing body of critical, qualitative literature into mental health and distress (Cromby, Harper, & Reavey, 2013), and particularly eating dis/orders (e.g. Bordo, 1997; Malson, 1998; Malson & Burns, 2009).

Current discourses of the eating dis/order unit do not seem to sustain nuanced constructions of therapists' embodiment. Dominant societal and professional discourses such as mind-body dualism, biomedicine, and the idealisation of thinness act to obscure bodily resources and bodily experiences that may help to overcome embodied distress. However, as Cromby (2015, p.1) attests, 'before anything else we are feeling bodies'. There is a need to make space for the complex and contradictory experiences of embodiment not seen through the lens of pathologised identity. Dualistic discourses are unhelpful. It is time to change our approach.

As demonstrated previously, the discourses drawn upon to construct the therapist's body replicate those thought to produce eating dis/orders. Idealisation of the individualised perfect professional body could be seen as a parallel process to that which is proposed to contribute to eating dis/orders. Examples of how services can parallel processes causing client distress can be found elsewhere (e.g. Emanuel, 2002). I do not wish to set up an idealised and unachievable position of therapist embodiment: Daly (2016) has used Winnicott (1971) to argue for therapists having a 'good enough' body attachment.

The findings suggest that therapists working in eating dis/order services may have a limited discursive repertoire for talking about their own and others bodies. Caught in a web of the ethically and professionally complex and contradictory discourses of the body, it is little wonder clinicians resort to silence on the subject. However, making the therapist's body unspeakable other than in corridors has serious implications for our work. I would argue that as clinical psychologists we need to explore alternative constructions of bodies that do not reproduce those implicated in eating dis/orders, for example drawing on critical, feminist and embodiment discourses.

Qualitative research aims to highlight and query taken-for-granted concepts and assumptions (Harding & Gantley, 1998). If we are to alleviate the eating and body distress of our clients we must have alternative language to

construct experience in a way that is non-pathologising, embodied, and contextualised. It is my belief that, rather than Othering the body, such constructions could do justice to the rich complexity of felt experience. I hope that this thesis will help clinicians reflect on their embodiment and how they position themselves in their work.

The findings have implications for therapists with personal history of an eating dis/order, who were interpellated into the position of pathologised professional Other, with repercussions for subjectification such as shame and silence. I hope to move conversations that occur in private to a more open, public forum in order to combat silence and associated stigma. By opening up a greater breadth of positions available for experts by both personal and professional experience we can empower greater service user involvement, an NHS priority. I believe such clinicians have unique insights to offer and would be an asset to services if they felt safer to share their experiences.

In terms of researcher advocacy (Fine, Weis, Weseen, & Wong, 2000), knowledge produced should have possibilities for improving the lives of people who are marginalised. My hope is that this research can be engaged with reflexively by clinicians in order to open up new discourses and wrest control of constructions of the body from the discourses of Cartesian dualism, biomedicine, and pathologised femininity.

4.7.1. Therapeutic practice

Afuape (2017) cautions against the dangers of treating our bodies as machines with no life in them, and how our work contexts often encourage us to ignore embodiment as unimportant background. However, the accounts in this thesis showed a paucity of discursive resources and subject positions for therapists to draw upon to construct and make sense of their own embodiment.

The accounts of the participants in this study augment previous literature suggesting therapists' body is important to and commented on by their clients,

and is constructed as impacting on the client-therapist relationship (e.g. Andersen & Corson, 2001; Katzman, 1993; Rance *et al.*, 2014; Vocks *et al.*, 2007; Warren *et al.* 2009). Existing literature argues that it is a crucial competency for therapists working in eating dis/order contexts to be able to address client concerns about the therapist's body (Williams and Haverkamp, 2010). Furthermore, the accounts construct changes in the therapist's embodiment are as meaningful in terms of embodied transference. Orbach (2003) argues from a psychoanalytic perspective that clients 'use our bodies just as they use our psyches' (p.31). Petrucelli (2007) suggests that while some clients may comment on the therapist's body, usually they will not, so sometimes clients invite us, sometimes we have to invite the client into making active, conscious meaning of the therapist's body.

When clients asked questions about the therapist's embodiment, some participants' accounts constructed this as a distraction within the therapy: "I just said that just, just yeah, just sort of said that the work was around helping her and, and not me." (**Frankie**: 133-134). It is challenging for therapists to be confronted about their own bodies and the right to privacy should be respected. However, being able to speak the unspoken and address client concerns are an integral part of therapy, and turning the question back on the client has been suggested to be not validating and pathologising (Jacobs *et al.* 2010). If therapists are able to tolerate co-constructing the meaning of their body with clients in a way that feels 'safe enough', they may find this provides new understandings, addresses the power differential, strengthens the therapeutic relationship, and has a positive impact on engagement and outcome.

In order to help them feel 'safe enough' to talk about their own body, therapists might spend some time preparing their bodies so as to meet clients in their preferred 'emotional postures' such as curiosity, openness and respect (Bownas & Fredman, 2017, p.7). Thinking about questions that use curiosity such as 'Why now?' might be helpful in exploring the meaning of the therapist's body. Furthermore, much of the communication in therapy is outside language. In many ways the process of re-embodiment therapeutic

practice – paying attention to body-to-body communication and what we do with our bodies in terms of voice, posture, facial expressions and gestures – does not require us to talk about bodies in therapy and can circumvent the challenges of written published research, which has to find a way of committing the nonverbal to disembodied text. In therapy, people can be with each other without the mediation of words, or as Petrucelli (2007, p. 237) eloquently says: “When a body meets a body, no formal introductions are made... As therapists, we focus on words but our bodies also speak.” Thus, the mindful practice of embodiment may lend itself better to practice than research.

4.7.2. Supervision

The need for attention to the therapist’s body in eating dis/orders supervision has been emphasised (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Hamburg & Herzog, 1990). In order for therapists to feel confident to discuss their embodiment with clients they need to be practicing these conversations in training and supervision. However, the research findings of the present study indicate there is a scarcity of language and time made available for conversations about therapist embodiment. This supports previous research that suggests the therapist’s body is largely taboo and unaddressed by professionals (Warren *et al.*, 2009). Systemic clinicians are beginning to theorise how therapist embodiment can be attended to in supervision (Bownas & Fredman, 2017), though there is not yet any literature addressing the specific challenges of supervision in eating dis/order contexts. Bownas describes the dearth in her repertoire for helping supervisees reflect on how they were experiencing and using their bodies when practicing therapy, compared to her well-developed skills for supervising language (Bownas & Fredman, 2017; Richards, Holttum, & Springham, 2016). Shaw (2003, p.46) argues that therapists ‘bring their own biological lived-body to the situation and it is by sharing these experiences that an embodied therapeutic narrative can be developed’. Reflective practice around the body could help supervisors and supervisees develop language for talking about embodiment.

In this sensitive context, body-focussed conversations should be respectful and supervisors should ask supervisee's consent to engage in 'body talk' or 'body practice' (Bownas, 2017). Supervisors may wish to gently introduce the subject of the therapist's body as early as possible in supervision, given the constructions of the work as impacting on therapist's embodiment initially and the subject as hard to talk about. A number of supervisees described looking to their supervisor to introduce the subject: 'we had group supervision so it was, like, you know it was never brought up in supervision, which is fine because I wouldn't necessarily want the other people there... but I do think its probably really important to have that *space*.' (**Robin**: 84-87). Participants in this study constructed talk about their own body within the power dynamic of supervision as difficult, potentially intrusive and shaming. Bodies were construed as a personal, private matter, one that was hard to address in group situations or where there was a large power differential. As many supervisees expressed concern that they were the only one whose body was impacted by the work, supervisors may want to normalise a wide range of experiences and impact, as something that commonly happens and make it known that supervision is a space that 'if it does, you can talk about it' (**Lily**: 119). Having the space to reflect is important to maintain therapist self-awareness and wellness. Some participants spoke of using other methods of self-care outside of supervision, such as personal therapy.

Reflective supervision regarding the impact of the work has been highlighted as crucial for ethical practice (Williams & Haverkamp, 2010). In participants' accounts, talking about a therapist's own body in supervision was particularly difficult when therapists had their own personal experience of an eating dis/order. Supervisors should be aware of the very real experiences of stigma and shame that recovered professionals may face, and inform themselves of the advantages having such expertise within the team can bring so as to offer alternative, depathologising positions (e.g. Bowlby, 2008; Costin & Johnson, 2002; Warren *et al.*, 2013b). Positively connoting supervisees facilitates exploration, and negative responses make it harder for people to take up different positions or change (Boscolo, Cecchin, Hoffman & Penn, 1987).

For detailed examination of practical approaches to therapist embodiment in training, reflective practice and supervision see Bownas & Fredman (2017). For example, Afuape (2017) sees supervision as a 'relationally responsive dialogical practice' (p.92) which involves focussing on the moment to moment *felt sense* in the body. Informed by social constructionist ideas, supervisors eschew the 'expert' position for reflexivity, encouraging multiple perspectives, encouraging supervisees to bring their unique perspective, and elicit feedback about usefulness of the approach (Afuape, 2017). Adopting a not-knowing position seems particularly important in this area, where the power differential closes down discussion and elicits shame. Such a dialogical approach might ask such questions as 'You say you felt [overwhelmed]. When you feel overwhelmed, what do you notice in your body? What might others notice in your body and your voice? Which posture/voice is more likely to invite the atmosphere you want to create? How would you prefer to be with this person? What do you want your body and voice to say?' (adapted from Fredman, 2017, p.77). Such social constructionist, contextual approaches to embodiment provide an alternative to discourses of mind-body dualism and pathology that silence body talk.

4.7.3. Service level

This research has a number of potential service level implications. Eating dis/order services should actively recruit to reflect the diversity of the clients they serve. Services have a responsibility to be transparent and explicit about their policy on welcoming and supporting 'recovered' therapists, given that a 'neutral' policy may translate into a 'don't ask, don't tell' ethos (Costin & Johnson (2002). There is increasing recognition of the importance of service user involvement, and therapists with personal experience have valuable expertise to offer, a 'secret strength'.

There is an assumption implicit in training, supervision and services that therapists will be able to talk about their own bodies if the need arises, in therapy or elsewhere. Yet this research has shown that body talk is difficult for multiple complex reasons. Training courses should promote reflection on

embodied ways of being in our work, and the multiple contexts that inform these positions. This could be part of training, and include what it might include role plays of what it might be like to talk about their body in therapy.

Leadership is increasingly a priority in clinical psychology. We have an ethical responsibility to think critically and reflexively about the gendered, embodied discourses of the eating dis/orders unit and society at large. Currently services seem to put the responsibility for introducing these conversations on supervisees or even clients. However, this is problematic due to the power differential, and acts to silence talk of bodies. The responsibility to make space to reflect on embodiment needs to be shared by eating dis/order services, training programmes, professional bodies such as the British Psychological Society, supervisors and practitioners (Warren & McGee, 2013).

4.8. Conclusions

This thesis makes a unique contribution to the literature through deploying a discourse analytic methodology to analyse therapists' accounts of their own body in eating dis/order services, providing an account of how societal, professional and biomedical discourses come to sustain multiple, conflicting constructions of the therapist's body.

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APPENDIX 1: University of East London Ethical Approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Pippa Dell

ASSESSOR: Mark Finn

STUDENT: Martha Kenyon

DATE (sent to assessor): 30/04/14

Proposed research topic: How do therapists who work with people with diagnoses of eating disorders talk about their own bodies?

Course: Professional Doctorate Clinical Psychology

- | | |
|--|-----|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | NA |
| 8. Is procedure that might cause distress to participants ethical? | YES |
| 9. If there are inducements to take part in the project is this ethical? | NA |
| 10. If there are any other ethical issues involved, are they a problem? | NA |

APPROVED

YES		
-----	--	--

A suggestion is that potential participants are given more of a general idea about topics of discussion in the participant invitation letter.

Assessor initials: MF

Date: 30/04/14

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)
--

SUPERVISOR: Pippa Dell

ASSESSOR: Mark Finn

STUDENT: Martha Kenyon

DATE (sent to assessor): 30/04/14

Proposed research topic: How do therapists who work with people with diagnoses of eating disorders talk about their own bodies?

Course: Professional Doctorate Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|--|-----|
| 1 | Emotional | YES |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: LOW

RISK ASSESSMENT APPROVED

YES		
-----	--	--

Assessor initials: **MF** Date: 30/04/14

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
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School of Psychology
Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



APPENDIX 2: Participant Information Letter



PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. The purpose of this sheet is to help you consider whether you want to participate in this research study. Please take the time to read the following information carefully.

What is the title of this study?

How do therapists who work with people with diagnoses of eating disorders talk about their own bodies?

What is the purpose of this study?

The purpose of this study is to explore how mental health professionals working in the field of eating disorders talk about and experience their own bodies. I will be particularly interested in your own narrative of these experiences. The study is being conducted as part of my Doctoral Degree in Clinical Psychology at the University of East London.

Why have I been chosen?

You have been approached to take part in the study as you are a mental health professional who routinely works with clients with a diagnosis of an eating disorder in NHS-provided mental health services. Eight to twelve mental health professionals will take part in this study.

Do I have to take part?

Participation in this study is entirely voluntary. It is your decision whether or not you take part. If you do agree to take part you are free to withdraw at any time, and you will not be asked to give a reason.

What will happen if I choose to take part?

You will be invited to take part in a confidential, one-to-one, digital audio-recorded interview with the researcher, Martha Kenyon. You will be given an opportunity to ask questions before and after the interview.

When and where will the interview take place?

The interview will last about an hour and will be arranged at a time convenient for you. It will take place in a comfortable room providing privacy either at your workplace or at the University of East London, whichever suits you best. You will not be paid or remunerated for your participation.

What are the possible disadvantages of taking part?

There are no known hazards or risks in taking part in this study. However it is possible that talking about your own experience of your body may be a difficult or distressing. Should you become distressed you will be able to take a break from or discontinue the interview at any point. The research will also provide you with details of suitable support organisations for example the relevant occupational health department.

**Will my taking part in the study be kept confidential?**

All information will be treated with the strictest confidentiality. To assure anonymity an identification code will be assigned to each participant, and you will be asked to choose your own pseudonym. Details of the identification codes will be kept separately and be accessible only to the interviewer. The consent form and demographic profile form, which bear your name and details, will be kept separately from transcriptions and the rest of the data. Interviews will be transcribed by the interviewer only, and will be anonymised as part of the transcription process, with all identifying material such as names and places changed. All paper data will be kept in a locked filing cabinet. Digital data will be stored on a secure, password protected hard drive. Passwords will be known to the researcher only. Only the researcher, internal supervisors and examiners will have access to the anonymised transcribed material. Audio recordings will be erased after the study has been written up but anonymised transcripts will be kept for further analysis for five years, at which point the data will be destroyed.

What will happen to the results of this study?

The results of this study will be included in a doctoral thesis. Your responses will remain completely confidential and your personal details will not be included in any documentation. You will be provided with an executive summary of the thesis. The findings of this research project may be published or presented at conference in future.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. You have the right to withdraw up until. Should you withdraw after the analysis has been written, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Contact for further information

If you are willing to consider participation or have any questions, please contact me, Martha Kenyon, at the email address below. If you are happy to participate you will be asked to sign a consent form prior to your participation. Please retain this information sheet for reference.

Researcher's details:

Name: Martha Kenyon, Trainee Clinical Psychologist
Email: u1236131@uel.ac.uk
Address: Doctoral Degree in Clinical Psychology, School of Psychology,
University of East London, Stratford Campus, University House,
Romford Road, Stratford, London. E15 4LZ

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Dr Pippa Dell, Head of Professional Practice in Psychology, School of Psychology, University of East

London, Water Lane, London E15 4LZ. Tel: 020 8223 4468. Email:
Pippa.dell@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark
Finn, School of Psychology, University of East London, Water Lane, London
E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)



Thank you in anticipation.

Yours sincerely,

Martha Kenyon

APPENDIX 3: Participant Consent Form

Consent Form

UNIVERSITY OF EAST LONDON

PARTICIPANT CONSENT FORM

Title: How do therapists who work with people with diagnoses of eating disorders talk about their own bodies?

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. I understand that the interview will be recorded, and that the data will be anonymised to ensure confidentiality. I give my permission for anonymised quotes to be used and for the data to be submitted for publication.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

APPENDIX 4: Demographic profile form

DEMOGRAPHIC PROFILE FORM

First name and surname / Code:

Contact details:

Please tick the box that best describes you, for each of the following areas:

Age:

18 – 25

☐

26 – 35

☐

36 – 45

☐

46 – 55

☐

56 – 65

☐

65+

☐

Gender:

Female

☐

Male

☐

Ethnic Group:

White: British

☐

Irish

☐

Any other White background

☐

Mixed: White and Black Caribbean

☐

White and Black African

☐

White and Asian

☐

Any other Mixed background

☐

Asian or Asian British: Indian

☐

Pakistani

☐

Bangladeshi

☐

Any other Asian background

☐

Black or Black British: Caribbean
African
Any other Black background
Other ethnic groups: Chinese
Any other ethnic group

Number of years since qualification:

Number of years of work with clients with eating disorders:

Theoretical orientation and speciality:

APPENDIX 5: Semi-structured Interview Schedule

Interview Schedule

Introductions

Informed consent (length of interview)

Consent form

Invitation to co-author interview agenda

The interview will start with more public questions and move onto more personal matters once rapport has been established (Yardley, 2008).

Co-authoring interview agenda

- Can you tell me a little bit about what interested you about taking part in this research?
 - What would you like to get out of taking part?

Participants' general work with EDs

- Can you tell me a little bit about your work in the field of eating disorders?
- How long have you worked in eating disorder services?
- What theoretical frameworks do you draw upon?
- How did you come to specialise in eating disorders?
- What has your experience been of working in eating disorder services and with this client group?

Participants' embodiment

- Can you tell me about your own experience of your body.
- Has your experience of your body changed since you started working in eating disorders? How/in what ways? What do you notice?
- Has the way you think about other people's bodies changed since you started working in eating disorders? How/in what ways? What do you notice?

- Has your relationship with food and eating changed since you started working in eating disorders? How/in what ways? What do you notice?
- Tell me how you manage the impact of...
- Who do you discuss these issues with? Do you discuss these issues with anyone outside of work?

Conversations about bodies in the eating disorder unit

- Do your colleagues talk about their own or each others' bodies?
How/where/when are they talked about? (*Prompt: in supervision?*) Has a colleague commented on your body/eating? How do you respond?
- How do you respond if a client comments of your appearance or eating?
Do you have conversations about your own relationship with your body with clients? With colleagues? In those conversations, how do you talk about your body? How do others talk about your body?
- Can you think of a piece of work where you felt your body was particularly relevant to the work?
- How comfortable do you feel with these conversations about bodies?
- Are there places and ways you feel more or less able to talk about your experience of your body?

Final questions

- How would our conversation have been different if you worked in a different speciality? What is different about the eating disorders unit?
- How has it felt talking to me today?
- Is there anything else I should have asked you?
- Is there anything else you would like to add?

Other questions/prompts

- Can you tell me more about...?
- Can you give me an example?
- What is your experience of...?
- How do you feel about...?

- How has changed over time?
- How do understand...?
- What sense do you make of...?
- What do you mean by...?
- How do (you/colleagues/clients) talk about...?
- What do you think people mean when they talk about...?
- What do you think the effects of are on the clients you work with?
- What do you think the effects of are on your relationship with your body?
- What do you think the effects of are on your own identity (as professional/woman/man etc)?
- What do you think the effects of are on your wellbeing?
- How do you manage the effects of...?
- Was there anything specific you heard/experienced that led you to...?

APPENDIX 6: Transcription conventions, quoting directly from Malson (1998, p. 239)

= indicates an overlap or absence of a gap between two consecutive utterances.

// indicates an interjection. For example, 'I think yeah/H:mm/ I could be like her.'

(.) indicates a pause.

Italics indicate where words or phrases are stressed.

[...] indicates that that part of the transcript has been omitted.

(inaud.) indicates where a part of the recording of the interview was inaudible.

() brackets surround words where the accuracy of transcription is in doubt because of the poor quality of the recording.

() brackets are also used to indicate where, for example, there is laughter.

[] brackets surround explanations that are not part of the transcript but are used to clarify the meaning of an utterance. For example, 'It [anorexia] was about not having feelings.'

[] are also used where extracts are quoted in the text to indicate where words have been altered.

Sounds such as 'mm' and 'uhr' are transcribed phonetically, as are colloquialisms, abbreviations, stutters and half-said words. Where utterances are not grammatical, punctuation is used so as to make the transcript as readable as possible.

APPENDIX 7: Stages for Foucauldian Discourse Analysis, adapted from Arribas-Ayllon and Walkerdine (2008)

1) Problematisations

Maps onto research question³ 1: How is the discursive object of the therapist's body constituted and made problematic? What discourses are available?

1.1. Discursive objects

Questions asked of the text: What is being constructed? (e.g. the therapist's body, the work, body image, weight)

This allowed identification of what objects, events and experiences were being constructed in the talk, particularly those relating to the therapist's body and physicality. This process highlighted all instances and references to the discursive object of the therapist's body.

1.2. Discursive constructions

Questions asked of the text: How is the discursive object being constructed? (for example, the therapist's body as ...'perfectly healthy'). The identification of the different ways that the discursive object is being constructed. Furthermore, areas of the text where the discursive object was *not* made reference to but might have been expected to were attended to, that might construct the discursive object as unspeakable or unknowable (Willig, 2008).

1.3. Discourses

Questions asked of the text: What discourses are being drawn upon to construct the discursive object in such a way? (for example, biomedical discourses) *What official discourses and counter-discourses render these problems visible, knowable and governable?*

Through focussing on differences between constructions, the analysis aims to

³ For research questions see section 1.13.

locate the various discursive constructions of the object within wider discourses (Willig, 2008). When I had read the transcripts multiple times, I returned to the literature of eating dis/orders and eating dis/order services, as well as broader professional discourses in order to ground the analysis within wider socio-political context.

2) Technologies

Maps onto research question 2: How is therapists' conduct governed at a distance (technologies of power) and by therapists themselves (technologies of self)?

Questions asked of the text: What technologies of power govern therapists' conduct? What are the institutional practices? Through which practices do subjects seek to regulate themselves?

The analytic foci involved identifying technologies of power and technologies of self governing therapist's conduct and their body. Technologies of power seek to govern individuals' conduct from a distance. Technologies of self are the techniques by which individuals 'seek to regulate and enhance their own conduct' (Arribas-Ayllon & Walkerdine, 2008, p. 99). At this stage of analysis I re-read and drew upon Foucault's work (Foucault, 1977), such as his conceptualisations of power.

Stage 3: Subject positions

Maps onto research question 3: What embodied subject positions and practices are made possible within these discourses?

Questions asked of the text: what subject positions are constructed? Do participants take up these subject positions? Do they position others within them? (for example, 'perfect professional')

The third analytic foci involved identifying subject positions to further elucidate the repertoire of discourses available. Discourses construct subjects and

make available various positions for participants to take up (or not), and to place others within (Foucault, 1979, 1988).

Stage 4: Subjectification

Maps onto research question 4: How do clinicians take up, negotiate and contest these processes of subjectification?

Questions asked of the text: How do clinicians take up, negotiate and contest these subject positions? What are the implications of these subject positions for what can be felt and experienced? 'How do subjects seek to fashion and transform themselves within a moral order, in terms of a more or less conscious goal, i.e. to attain wisdom, beauty, happiness and perfection?' (Arribas-Ayllon & Walkerdine, 2008). What are the implications of these discourses, and subject positions outlined above for ways-of-being in the eating dis/order unit? (Willig, 2008)

The fourth analytic foci was concerned with processes of subjectification and implications for subjectivity. Subjectification refers to the ethical self-formation of the individual subject (Arribas-Ayllon & Walkerdine, 2008). Discourses make available 'certain ways-of-seeing and ways-of-being in the world' (Willig, 2008, p. 117). Subjectification or taking up various subject positions has implications for participants' subjectivity, including their embodiment.

APPENDIX 8: Example of Hand Coded Printed Transcripts

Transcript 1
Olivia

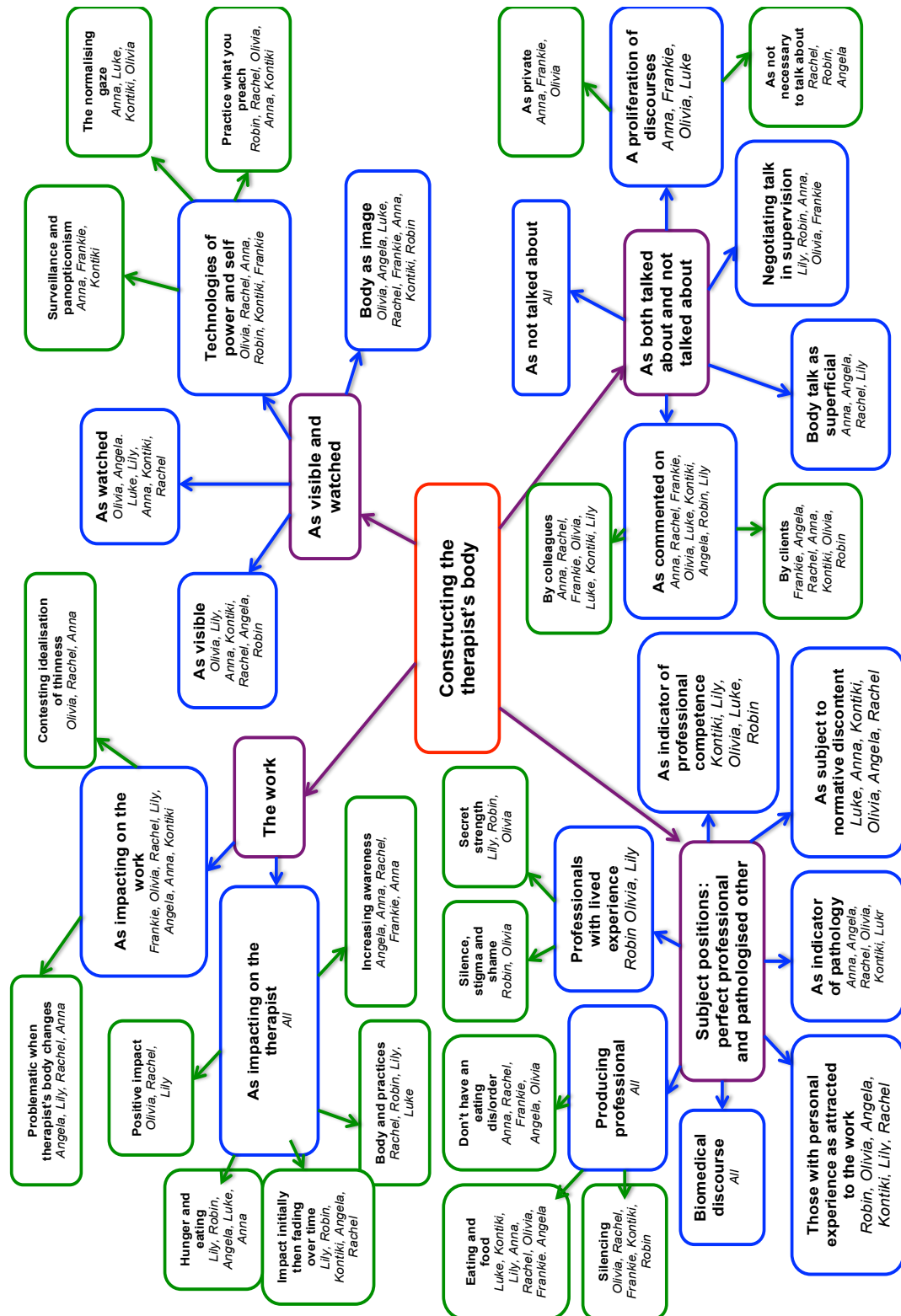
body	460	subject - body
client	461	subject - body
personal experience	463	subject - body
	464	subject - body
	465	subject - body
	466	subject - body
clinical working in CB	467	subject - body
expert - but - experience	468	subject - body
immune - acronym	469	subject - body
- really know where it leads	470	subject - body
	471	subject - body
	472	subject - body
	473	subject - body
	474	subject - body
EB work	475	subject - body
	476	subject - body
	477	subject - body
body image	478	subject - body
	479	subject - body

body disturbance and I just wonder how that affects their own body dissatisfaction. (M: mm/ I know um in terms of how it effects my body dissatisfaction I really honestly can't say that I've ever felt triggered by a client in terms of sort of wanting to lose weight wanting to get differently. (I really the reaction that comes from me is a sort of sadness almost.) (M: mm/ I'm feeling of like I feel sad that that person is still stuck in that awful place because I know skinny what awful place that is M: mm/ um (I) I don't ever feel like oh I wish I was that skinny or like these (I) you know there's never been a triggering conversation M: mm/ but I wonder for some women working with these patients if they also feel dissatisfied with their body so their actively fixing privately or whatever (I) I really wonder if if that is the same experience (I) like I said I almost feel immune to this shit like M: mm/ I was ill for nearly ten years M: mm/ like I'm so over feeling crap about myself M: yeah I mean are there times when I sort of look in the mirror and think I would look better ten pounds lighter (I) shit -dissatisfying packed with yes of course M: mm/ um / know would I like to fit in a size ten rather than a size twelve um sometimes but I just (I) know where those thoughts lead (I) M: mm/ I keep a check on them and I just it's not worth my mental health basically M: mm/ um I think it's about my happiness and everything M: mm/ so I (I) me personally I don't think it um is negative in a negative way but I do wonder about (I) the other what ninety five percent of people that work in eating disorders and whether or not they feel they have as much of a robust body image because the reality of the fact is that not everybody does (I)

Psychiatric/expect as code
PERFECT HEALTHY PROFESSIONAL

[illegible]

APPENDIX 10: Diagram of analysis, showing representation of sample against each construction of the therapist's body⁴



⁴ Constructions in bold, participants in italics